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Which degree? : the influence of perceptions of professional nursing issues and professionalism on course selection.

Which Degree? The Influence of Perceptions of Professional Nursing Issues and Professionalism on Course Selection

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Abstract

The research investigated nurses' choice of post-registration degree at a particular institution of higher education in order to address the unexpected popularity of the BSc in Health Studies. In particular, it sought to examine choice of degree against the background of changes in professionalism.

The literature review covered the development of nursing and nursing education, professionalism, professionalisation, the concept of occupational closure and relevant gender issues.

A combination of quantitative and qualitative methods was used for the investigation. Analysis of questionnaire data revealed differences between community and hospital-based nurses. It confirmed that community nurses selected the Health Studies course originally designed for them as a rational 'follow-on' from courses that led to their professional recognition and qualification to practice community nursing. Hospital nurses were almost evenly distributed across the two courses and were revealed to be of critical interest. Those on the Nursing Studies course conformed to expectations and might be seen as relatively passive in attitude, whereas Health Studies participants were cosmopolitan, held stronger views about their choice of degree and made a 'deviant' but not illogical choice of course.

The second, qualitative stage, used in-depth interviews of 15 hospital nurses. Hitherto unsuspected relationships were discovered between the academic content of courses chosen by students and their orientation, values and attitudes towards nursing per se and their perceptions of the present and future status of the professionalisation of nursing. Health Studies participants were more likely to reject the utility of nursing theory and models, to feel more negative about nursing currently and more pessimistic about the future than their Nursing Studies degree counterparts. Hospital nurses on the two courses appeared to espouse different models of professionalism, with Nursing Studies participants aligned with the altruistic 'functionalist' model in contrast to their Health Studies counterparts who leaned towards conflict models.

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DECLARATION

I declare that the work in this thesis was carried out in accordance with the Regulations of the University of Bristol. The work is original except where indicated by special reference in the text and no part of the thesis has been submitted for any other degree.

Any views expressed in this thesis are those of the author and in no way represent those of the University of Bristol.

The thesis has not been presented to any other University for examination in the United Kingdom or overeas.

Signed .....

Date ..... 30 September 1999

Contents

Figures and Tables

Chapter One

Introduction and Rationale for the Research

Modern professional nursing is a complex activity that makes heavy demands upon individual nurses, the organisation of the nursing service and teamworking skills with fellow nurses, doctors and other health care professionals. High standards of nursing imply safe, effective and efficient care through deployment of the appropriate nurse, or team of nurses, with the requisite knowledge, skills, awareness of the clients' needs, a positive professional attitude and high morale. These should be considered to be the normal requirement for the provision of a nursing service, not the ideal, but nursing is frequently in the news for failure to deliver an acceptable quality of care, often in the face of inadequate resources.

The level of knowledge and professional skills of registered nurses is crucially important to equip them to understand and tailor their care to take account of advances in medical science, pharmacology and technological innovation. The pace of these developments has led to increased complexity of treatment, greater expectations by the consumers of health care but, at the same time, a higher risk of errors being made and with the threat of more serious implications when things go wrong.

Curriculum development teams in Higher Education Institutions (HEIs) endeavour to produce courses that they believe will best meet the needs of their students - within the resource constraints that they operate under. HEIs explicitly design post-registration degree courses to enable students to acquire and apply higher levels of knowledge and skills in their practice. In some institutions, as was the case in this research at the Royal College of Nursing Institute (RCN Institute), several degree courses were designed to meet the needs of distinctly different nurses. One course, the BSc in Nursing Studies, was designed and introduced in 1987 for hospital-based nurses. The other, the BSc in Health Studies, was designed for community nurses and started in 1990.

Reasons for this Research

This research was undertaken to shed light upon the reason why, unexpectedly, the BSc in Health Studies became more popular among hospital nurses than the BSc in Nursing Studies. The academic staff of the RCN Institute had expectations with regard to which courses community and hospital nurses would be likely to take. It was intended that there would be clear benefits to community nurses by taking the Health Studies degree, since there were a number of modules that were specifically focused upon aspects of community care. It was also thought that the Nursing Studies degree would be more suitable for hospital nurses than the Health Studies degree because some modules on the former were oriented towards hospital care.

Although it was realised that the proportion of hospital-based nurses on the Health Studies course was rising, because the Institute's database did not contain data relating to the workplaces of course participants, the precise number of hospital nurses who were taking it was unknown. It was considered necessary, therefore, to collect this 'missing' data, identify and understand the factors that influenced course choice and to gain information about students' expectations and perceptions of their degree course experiences.

Beyond the students' decisions to enhance their knowledge and skills that would accrue from taking either of these courses, or indeed, many other degree courses that the Institute or other higher education institutions offered, it was not known what factors were influencing the choice of degree course. The researcher believed that the reasons were likely to be found in circumstances that led up to the position that nurses found themselves in and that their decisions were being influenced by their perceptions of their present professional situation and the future career possibilities that would arise within nursing and perhaps outside of nursing.

Irrespective of degree course choice, the strength of the students' motivation towards extending their nursing education was not in doubt. Nurses taking a post-registration degree do so because they wish to improve their nursing performance

through the application of greater knowledge and skills and to enhance their career prospects. But the performance of a nurse is not only determined by tangible and measurable knowledge and skills but also by the relatively intangible *attitudes* that a nurse has towards her/his work environment.

Attitudes are shaped by a person's perception of her/his social reality (Berger and Luckmann 1967), especially, how well they fit into their profession and their workplace. For most individuals the most influential factors are, relationships with others, their degree of job satisfaction, their assessment of their career potential and the level of their self-esteem. A nurse's perception of her/his social reality will affect motivation towards work, morale, professionalism and her/his stance on professionalisation.

Not all nurses share the same perceptions and, when two nurses hold significantly different perceptions, each respectively, may find one course more attractive than the other. Could there be differences in perception about the future development of nursing and health care arising during the period of intense change that has been experienced since the mid-eighties in particular? Were there differences in perception about their own current and anticipated future circumstances that had a bearing on course choice? Apart from the fact that they had already chosen to work in different sectors, were community nurses different in other significant respects than hospital nurses? Were there significant differences in perception between the hospital nurses who had selected the Health Studies course compared to those who had chosen the Nursing Studies course? These were thought to be key areas that required investigation.

The elucidation of factors that influence nurses in making decisions about course choice is likely to have implications that extend beyond these specific courses and the RCN Institute but could usefully inform those responsible for nursing and nursing education elsewhere.

This dissertation

This dissertation outlines the development of nursing over the past three decades during which considerable changes occurred in nursing structures, nursing practice and nursing education. It examines concepts and models of professionalism and professionalisation, focusing, in particular, on inter-relationships between medicine and nursing. It questions whether nursing can be accepted as a profession or whether it should be considered to be a non-professional occupation.

Based on the knowledge that, against the expectations of the academic staff who designed the courses, an increasing number of hospital nurses were choosing the Health Studies degree, three research aims and a number of research questions arising from them were formulated to elicit the reasons why. These are set out later in this chapter. The strategy was to collect quantitative data from the whole population of community nurses on the Health Studies course and hospital nurses on both courses for comparison of key characteristics and identification of aspects for in-depth interview of a small sample from each of the critical groups of nurses. The research was designed to address the research questions posed with a view to discovering the reasons why the individuals who participated in the qualitative part of the research made their decisions and whether those reasons could be related to theoretical knowledge or constructs. As will be revealed later in this dissertation, the choice of degree course among hospital nurses was not simply a positive decision made on the knowledge and skills content of the courses disclosed in the course literature or a direct relationship with their professional roles, but instead, for many, other factors were paramount in their decision, including, 'dislike of nursing theory', 'perceptions about a future career' and 'allegiance to different models of professionalism'.

It is necessary to appreciate the historical background to nursing and nursing education in order to contextualise the circumstances that led up to and pertained during the decade of the 1990s - the period during which the subjects of this research study worked and undertook the degree courses in question. The historical development of nursing will be outlined with particular reference to its

relationship with the medical profession and the management of the health services. It will be seen that the extent of the changes has been considerable, with an increasing acceleration in the pace of change over the last three decades. The changes in nursing have necessarily been accompanied by changes in nursing education but, as will be seen, the changes in nursing practice and nursing education lacked synchronisation. An understanding about the comparatively recent move of nursing education from the National Health Service to the Higher Education sector and the growing importance of post-registration degrees for nurses is crucial to an appreciation of the nature of the investigation and the findings and conclusions of this research and these are discussed.

The following sections in this chapter provide the basis for discussing the rationale for the research and the framing of the research aims and the research questions arising from them. The final section of this chapter outlines the content of the remaining five chapters that form this dissertation.

The Development of Nursing

Nursing is a vital occupation that is unavoidably involved in social, economic and political struggles with those who occupy more powerful positions and exert control over occupational practices and financial resources, namely the medical profession and health service managers. This has been the position since the advent of modern nursing and it is not likely to change fundamentally in the times ahead, although the issues which come to public notice will change contemporaneously with the preoccupation and vicissitudes within the broader society. Nurses have had only limited control over their practice and this has been the root cause of their struggles as will be revealed in more detail in chapter two.

For the great majority of nurses, although they have been aware of the issues, they have not been personally engaged in an organised, systematic way. There have often been differences between what nurse leaders have been trying to achieve and the perceptions of the rank and file. Indeed, the nursing literature contains numerous references about nurses in general being apolitical and apathetic with

respect to action to enhance their collective position, with pleas to them to become more involved and cohesive in striving for professional betterment (White 1985: x, Parkes 1986: 115-116).

The development of nursing as a profession has been a slow process. Compared with all occupations nursing has enjoyed a relatively high status. However, what is of greater significance is the comparison between nursing and occupations with which immediate comparisons are made. Nursing not only has a lower status than the medical profession but also with such semi-professions as teaching and librarianship, since in the revised occupational classifications to be used by the Office of National Statistics for the 2001 census, nursing remains in category two, whilst schoolteaching and librarianship have joined medicine and law in the lower half of category one.

The determinants of occupational status are complex and derive from the characteristics and background of entrants, the length and rigour of professional preparation, the nature of work undertaken and the nature of the work context. Without assigning a particular weighting in the determination of the status of nursing, it can be suggested that the fact that nurses work alongside doctors who are members of a historical prestigious profession with a strong boundary is a significant factor.

Doctors have established strong control over their own professional position and to a large extent exercise control over what nurses can and cannot do. Doctors have individual autonomy, are collectively well organised and cohesive when their interests appear to be under threat. They are adept at extending their influence over society by political means and by exploiting scientific advances and technological development through claiming expert knowledge, guardianship of medically safe practice and stewardship of the public good over a wide range of issues. They have continued to consolidate their position by the medicalisation of significant areas of society, a process that has been called the expropriation of

health (Illich 1976:42). The influence of the medical profession on nursing is more fully explored in chapter two.

The process of professionalization is rarely smooth and can involve setbacks and ambiguities for its members at any stage, even for professions that are well established. Professionalisation is the process by which an occupation such as nursing successively meets the criteria that are alleged to characterize such occupations as medicine which have historically been regarded as professions. However, professionalisation has two components – the improvement of status and the enhancement of the qualities of practitioners which may not always proceed pari passu, thereby creating a tension. Thus a balance has to be achieved. The prevailing balance is currently being strongly challenged in some instances. For example, the professional criterion of practitioner autonomy in medicine is, in the wake of a number of well-publicised cases, experiencing a serious challenge.

More relevant to this study is the tension between the commitment of nursing to academically credible qualifications and commitment to the practical aspects of patient care. At the pre-registration level academic preparation required enhancement and this has been at least partly addressed by the Project 2000 reform of pre-registration education (UKCC 1986) but disquiet about the practical competence of newly registered nurses has been commonplace. Beyond registration, again the statutory body has formulated a post-registration and practice framework (UKCC 1995) but the onus is on individual nurses to commit themselves to suitable courses that will provide them with advanced knowledge and practitioner skills necessary for the advancement of the profession as a whole and their own advancement within it.

Pre-registration Nurse Training

Hospitals were responsible for pre-registration nurse training from its formal introduction following the establishment of the General Nursing Council in 1919 until the transfer of responsibility to the higher education sector in the early 1990s with the change to the Project 2000 education programmes. Hospitals ran training

schemes mainly because they were dependent upon nurse trainees to supply nursing service to their patients - 60% or more on a ward being provided by students was commonplace. For all of this time there was dissatisfaction on several accounts expressed most clearly in the Wood Report (HMSO 1947), the Briggs Report (1972), and the Judge Report (RCN 1985). Dissatisfaction was expressed about the shortage of students and qualified nurses which was endemic, and a range of educational concerns, about the quality of training because of the low standard of entry, courses pitched at too low a level (below higher education level), chronic shortages of nurse teachers, and an inadequate amount of time available for educational purposes due to service-giving demands (only 30 out of the 156 week training period was prescribed for strictly educational purposes between 1969 and 1989 and it was far less than this prior to 1969).

The biggest change came in 1989 with the introduction of the Project 2000 course by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Project 2000 courses are different in several respects from the earlier nurse training courses (UKCC 1986). They are based in the higher education sector and lead to a Diploma in Higher Education, require A level GCE passes or equivalent, are designed and run to achieve educational objectives rather than service-giving and, when students gain practical experience in direct patient care they are supernumerary to the regular staff.

Importance of Post-Registration Nursing Degrees

The need for a higher level of knowledge and skill for nurses was recognised by health care organisations, the statutory bodies for nursing, professional nursing organisations and higher education institutions (HEIs) and an increasingly significant number of nurses take post-registration degrees. The importance attached to enhanced knowledge and skills has accelerated over the last 15 years and is reflected by the following developments. Many higher education institutions developed degree courses for nurses, the English National Board for Nursing, Midwifery and Health Visiting introduced The Framework for Continuing Professional Education and the Higher Award (ENB 1991), and the

United Kingdom Central Council for Nursing, Midwifery and Health Visiting set new standards for practice and continuing educational preparation (UKCC 1994). The RCN Institute was one such higher education institution that introduced a number of bachelor and higher post-registration degrees for nurses that were designed to provide them with enhanced knowledge and skills in nursing per se and in other subjects relevant to nursing practice.

The RCN Institute and Degree Programme Development

Nursing encompasses a wide and diverse range of work and depends upon theory from many of the life and social sciences and the humanities to underpin practice and, in order to examine students at the required academic depth, it is necessary to select comparatively few areas of content for study. Each HEI adopts a policy and regulations concerned with the academic content of each course and there are two fundamentally different approaches for doing this. Courses may be wholly *prescribed* with no choice for students in what they can study. Alternatively, courses may be made up of a defined number modules of subject matter selected by students from a much greater number of modules across a wide range of subjects - a *liberal* approach.

These two approaches, *prescriptive* and *liberal,* may be considered to be two extremes and most HEIs will offer courses that fall some way between them. The RCN Institute policy on this was based on the liberal approach and on most of its courses no more than one third of the modules were prescribed. For a particular course, the prescribed modules reflected the anticipated needs of the intended clientele, the 'balance' of modules were chosen by students to suit themselves. Two such courses were the BSc in Nursing Studies, designed for hospital-based nurses and the BSc in Nursing Studies which was designed for community-based nurses.

When this research was started in 1996, the RCN Institute in London was the world's largest provider of post-registration courses for nurses, with around 1250 students, of whom 91% were part time. The Institute has been running post-

registration courses at undergraduate diploma level since 1926 but it was not until 1987 that the first degree course was introduced. This was followed by many more degrees over the next seven years and by the 1994/95 academic year, when the first of the subjects studied in this research graduated, eight honours and six masters degrees were on offer.

The Nursing Studies degree started in September 1987 and the Health Studies degree course three years later, in September 1990. Both degree courses are unitised modular courses with the modules set at three academic levels. An honours degree is awarded for the accumulation of 360 points or more, with a maximum of 120 points at academic level one - equivalent to the first year of full time study, or the award of a Certificate in Higher Education, and a minimum of 120 points at level three, including a dissertation valued at 40 points. There was no specified number of points at level two, thereby enabling students to choose additional level three modules that could broaden the range of subjects available to them to study. The majority of students choose level two modules to a value of 120 points but a lot accumulate more level three than level two points.

The Institute operated a 'progression' model in terms of qualifications, whereby Certificands could progress to a Diploma (minimum of 240 points of which at least 120 would be at levels two and/or three), and Diplomates could progress to a degree course. These progressions used the principle of 'accreditation for prior academic and experiential learning' (APEL), which also applied to applicants with acceptable credit rating gained elsewhere. The modular scheme, with APEL, facilitated both full time and part time study and the taking of time out from study to fit in with changes in students' professional and personal circumstances.

When the Nursing Studies and the Health Studies degrees were being developed, those in the Curriculum Development Groups were mindful of the differences between hospital and community nursing and shaped the courses to reflect these and other conceptual differences. The Nursing Studies degree course contained core compulsory modules that were concerned with models of nursing care and nursing theories and concepts that were more closely allied, although not exclusive, to

hospital nursing. The level 3 modules in particular, were designed to enable those holding diplomas in nursing, both postgraduate and later, pre-registration Project 2000 diplomas, to 'top-up' in the most logical and economic way.

Similarly, when the Health Studies degree was developed some three years later, the 'top-up' needs of community nurses were borne closely in mind. Several core modules based on concepts of health and illness prevention, formed a 'compulsory group' from which a certain number would have to be chosen, dependent on which qualification was held and which previous study had been undertaken by the given student. These modules were especially relevant, but were by no means exclusive to community nurses. Specialist modules in occupational health nursing and 'pharmacology for prescribing' were in the Health Studies degree programme to reflect developments in national policy. A significant number of students on the course were holders of Occupational Health Nursing certificates and diplomas and the Nurse Practitioner Diploma. There were, therefore, expectations that hospital-based nurses would choose to take the Nursing Studies degree and that community-based nurses would opt for the Health Studies degree.

There are some differences in the structures and the ranges of modules available that distinguish the two degrees from each other but these would appear to be marginal. The Health Studies degree programme comprises a total of 47 modules, including a group of 10 from which a minimum of 3 must be taken. No fewer than 39 of the modules are common to both degrees, including Research in Practice and a dissertation of 10,000 words. The Nursing Studies degree also has a 47 module inventory including a group of 3, from which a minimum of 2 must be taken.

The introduction of the Nursing Studies degree in 1987 also marked the start of the modularisation programme and in the first year only 5 modules were available to these particular students. In every year since, each of the five Programme Studies Boards (PSBs) had developed more modules and the size of the overall programme grew rapidly. Each PSB made the majority of their modules available to the others and also incorporated most of the modules that became available into the degrees for which they had responsibility. The Health Studies and the Nursing

Studies PSBs incorporated by far the most and because they made their decisions independently there was little, if any, attempt to make further distinctions between the two degrees. This contrasts sharply in the positions taken by the Education, Management and Midwifery PSBs where, because the degrees in these subjects are much more focal, the number of modules 'imported' into their degree programmes was considerably lower.

Popularity of the Health Studies degree

The 'generic' BSc in Health Studies became the most successful course of all, in-so-far as applications and student enrolments are concerned and by 1994 well over twice as many applications were received for the BSc in Health Studies than for the BSc in Nursing Studies, the second most popular course. Neither of these two degrees prepares the graduates for specific professional roles, unlike some of the other degree programmes that the Institute runs, (eg BSc in Children's Nursing). Although the Registry's Computerised Management Information System (CMIS) did not contain data about the work roles or places of work of the individuals registered on the courses, it was realised that many who registered for the Health Studies degree were hospital-based. Superficial comparisons of personal data of the Health and Nursing student cohorts, using the CMIS, did not reveal anything of significance between them. However, it was clear that nurses were making deliberate choices about taking one or the other degree.

The popularity of the Health Studies over the Nursing Studies degree led to the expression of concern by a number of senior nurses who already considered that nursing in the contemporary National Health Service was under increasing pressure from a predominantly managerial culture that constrained the development of nursing and led to the downgrading of many nursing posts. The largest professional association for nurses, the Royal College of Nursing, was anxious to reverse what it thought to be a decline in the influence of the profession by mounting its 'Right to Nurse' campaign (RCN 1992). This was intended to enhance the image of nursing with the public, other health care professions, NHS managers and, not least, among nurses themselves. It was, therefore, somewhat

disconcerting for the RCN to see an apparent shift in the preferences of nurses from the more focal Nursing Studies degree to the broader Health Studies degree.

All Institute courses were marketed jointly through the Institute Prospectus with no attempt at differential promotion with regard to the strength of recruitment. However, the Health Studies and Nursing Studies degrees were the responsibility of different Programme Studies Boards (PSBs). The five PSBs represented the lowest level in the academic infrastructure where decisions were made about courses. They constitute what Becher and Kogan (1992) refer to as 'basic units' of academic decision making. Almost all academic decisions about the degrees that they are responsible for are made by the PSBs, including the development and incorporation of additional modules into the degrees. The Academic Board, to whom the PSBs are accountable, became directly involved when policy reviews were necessary and when a course was due for revalidation.

After a decade of development of the Bachelors degree programme with virtual freedom for each of the PSBs to tailor their courses independently, a number of policy issues surfaced. The principal ones were; levels of recruitment to each of the different courses; whether module choice on one or more of the degrees should be more restricted; and whether module 'overlap' between the Health Studies and Nursing Studies should be reduced. These are policy implications that fall within the aegis of the Academic Board and it was felt by some academic staff that it should determine the direction of future developments in relation to these matters.

Academic staff within the Health and the Nursing PSBs raised the student enrolment issue and also suggested that adjustments may need to be made to the module inventories of each of the courses. Lecturers in Nursing contended that there should be greater differences between the two degrees and in particular, fewer modules that are common to both. This point of view appeared to have legitimacy and suggested that there were sufficient grounds for reviewing the rationale for, and the nature of, each of the degrees. However, it must be recognised that the different groups of academic staff each have vested interests in

creating conditions that are more advantageous to themselves. What any particular grouping of academics may advocate has to be viewed as objectively as possible by the Institute as a whole - at the Academic Board level. The views of the students needed to be ascertained and taken carefully into account before matters of policy are decided. Indeed, it could be argued that on any post-qualification vocational course, the views of students and graduates should be accorded the greatest weight, save for the maintenance of academic standards per se.

Rationale for the Research

From the foregoing comments, three distinct issues are apparent. The first issue is why students choose which degree to take. Those who register for these two degrees are apparently making a clear choice between the Health Studies and the Nursing Studies degrees. What influences them to make their particular choices? Influences operating on them can be expected to fall into positive ones - swaying students towards one or the other and, or negative ones - that dissuade students from one or other degree.

It occurred to this writer that the nurses participating in this research would be likely to hold a range of concepts about professional issues, for example the relationship of nursing to the medical profession. Some will be well aware of the nature and strategy of the continuing struggle of nurses to advance their profession against resistance of doctors, who see a need to control nursing so that a medical agenda has priority (Walby and Greenwell 1994: 53). The researcher believed that this awareness would be sharply focused in their everyday work and in their relationships with doctors and other nurses. It was considered probable that their experiences and opinions would vary and would depend to a large extent upon their own type and place of work and the personalities of other important actors therein. Their own expectations and aspirations about their future careers are also likely to be influential. One can speculate that they wish to expand their individual work roles and to increase their job satisfaction in tangible ways. Their academic development should provide them with a greater ability to express their case more articulately and with greater confidence.

Nurses intending to study for a degree may be influenced by professional colleagues either towards or against a particular course. Positive influences are most likely to be generated from those with whom they work whose opinions they particularly respect (Rodgers 1962). They may look up to people as professional role models and take positive steps to emulate them. They are likely to shape their continuing professional education in order to best equip themselves according to their vision of what is required for the positions they aspire to. Alternatively or additionally, factors that could influence the choices made by students may stem from within the Institute itself. Perceptions generated from the promotional material, especially the Prospectus, or through the attitudes and nuances that potential students may interpret from the Registry or the academic staff may be sufficiently influential to some students to shape their choice.

The second issue concerns the possibility that a degree in nursing is somehow looked upon as being a less valuable asset than a degree in health studies. The prima facie position gives support to the notion of a relative 'devaluing' of nursing by Health Studies students. It is necessary to clarify whether Health Studies students perceive nursing differently and value nursing less than Nursing Studies students, and, if so, to elicit the reasons why. A student's decision to take one or other of these degrees can be expected to be influenced mainly by the academic *content* of the respective courses. Content may be viewed positively, as when preferred academic or professional subject modules can be chosen to make up the degree, or negatively, when a student decides not to take a course that contains compulsory modules that s/he wants to avoid.

The difference in content of the two degree courses, small as it appears, can be crucial to many of the students. The Health Studies degree may be conceived by some as being more forward looking, more oriented towards prevention of illness and a positive lifestyle because of its greater focus on health education, health promotion and health psychology. This is a reflection of the same philosophy that was stated by the United Kingdom Central Council (UKCC) as the underpinning of the Project 2000 courses (UKCC 1986). The Health Studies course title may

also be thought to suggest greater flexibility, to be more marketable and to enable a wider range of career options in the future, compared with the Nursing Studies degree.

The inclusion of compulsory modules devoted to nursing theory and nursing models may be seen as an incentive to take the Nursing studies course by those who believe that knowledge of them and their use in practice can lead to an improvement in the quality of care. Alternatively, nurses who are unconvinced of the value of nursing theory and models, or who believe they are already conversant with them, may wish to study other areas in which they have greater interest. It is possible that the two populations hold different concepts of nursing and contrasting opinions about the importance of nursing theory and the utilisation of published nursing models in their nursing practice. A more extreme view was known to be held by some nurses; those who believe that they will not gain anything tangible by a knowledge of nursing theory and models and who would wish to avoid studying them. Nurses holding the last two of these views would be likely to avoid taking the Nursing Studies course and to opt for the Health Studies course instead.

Another, though probably lesser reason for degree choice, may be the *title* of the degree. The term 'nursing' in the title may be an attraction to those who believe that it signifies a further endorsement of their chosen profession and reinforces their accomplishment and career choice. For others, perhaps less committed to nursing, or who view themselves more broadly as a 'health promoter', having 'health' in the title may appear to be a more modern and a more apt term. This may also be regarded as an advantage should they later seek a change of career outside of nursing.

Professionalism and professionalisation in nursing are real issues that nurses are frequently, if not continuously, aware of. In all specialities within nursing there are matters that are contested between nurses and doctors. Nurses are endeavouring to expand their practice into new areas, most of which are currently in the medical

domain, for example, prescription rights for a greater range of medications, the performance of minor surgical procedures and deciding when patients are well enough to be discharged from hospital, are three examples of demarcation issues at the medical - nursing boundary. But they are by no means the only areas of actual or potential conflict.

It is likely that most of the participants on the two degree courses will have well formed opinions and attitudes about autonomy. It is likely that those who feel strongly about the need to make a positive contribution to the advancement of nursing through expansion into the medical domain, will have been conscious that degree level studies are likely to put them in a stronger position, through enhanced knowledge and skills, the ability to better argue their case and in their currency to obtain professional advancement. It is also likely that they hold a range of views about the nature and meaning of profession and they may well hold views that are aligned with different models of professionalism. This research will investigate the opinions and attitudes of interviewees about professional matters and seek to identify differences. Contrasting models of professionalism will be discussed through a review of the literature in chapter two.

It is also possible that the Health Studies participants have a wider vision of nursing, and are more 'cosmopolitan' in their professional orientation, compared to those who chose the Nursing Studies course. If any of these differences in perception or orientation should be discerned, it is likely that similar phenomena will occur across the whole profession, rather than just within the Institute. It may be that the RCN Institute, by offering these two choices of post-registration course, provided the opportunity for making a choice, that for some nurses, reflected a difference in perspective and outlook.

Whatever motivates the students towards making their choice, the Institute needs to be aware of and, indeed, to understand the student position, in order to enlighten and guide curriculum development, focus or defocus promotional material and enable potential and actual students to appreciate the range of

perceptions shared by the profession at large about post-registration education and practice.

Purpose of the Research, Aims and Research Questions

Having discussed the background of the institutional dilemma and the development of the degree programmes and the issues emerging from them, which have been identified in the rationale, the research project can now be clarified. The primary purpose of the research was to elicit fundamental concepts and attitudes among nurses towards nursing and continuing professional education that led to them choosing to take the either the BSc in Health Studies or the BSc in Nursing Studies. Accordingly, the aims and the research questions that arise from each of these aims were formulated as follows:

Aim 1. *To ascertain the professional profiles of those choosing the Health Studies and the Nursing Studies degrees, in particular of those nurses working in hospitals.*

Research questions arising:

1.1 What are the characteristics of the people who apply for these different degrees, in terms of present employment, age, educational and professional qualifications and professional history?

1.2 Are there differences in the profiles of hospital and community nurses and between hospital-based nurses on the Health Studies and Nursing Studies degrees?

Aim 2. *To compare course selection with its utility for practice.*

Research questions arising:

2.1 How much care did students take in choosing their degree course?

2.2 What reasons did interviewees give for their degree course choice?

2.3 How valuable did students find their degree course to be in terms of their current and intended professional roles?

The matters that relate to aims 1 and 2 and the research questions arising from them are the subject of the quantitative phase of the research. Research question 2.2 was also used in the qualitative phase to augment and enrich the quantitative data from the interviewees. Some of the data that are necessary to obtain a profile of the characteristics of the two degree populations are held on the Institute's registry database. Additional quantitative data were collected through a postal questionnaire survey of the whole of the two degree populations.

***Aim** 3. To determine whether there are differences in module patterns, values, opinions, attitudes and behaviour between hospital nurses on the Health Studies and the Nursing Studies degrees that may be related to their choice of degree.*

Research questions arising:

3.1 Are there differences in the patterns of module types in the make up of the two degrees?

3.2 Do graduates/students have different opinions and attitudes about nursing theory and models?

3.3 Are there differences in the perceptions that graduates/students have about professionalism and professional issues?

The matters that relate to aim 3 and the research questions arising from it are the subject of the qualitative phase of the research. The profiles of the respondents to the postal questionnaire were analysed and a selection was made of nurses who were approached for an in-depth interview. The subjective data collected during the interviews were used to address this research aim and the related research questions.

Structure of the Dissertation

Chapter 2. Literature Review. It is not possible to understand the complexity of the nursing environment and the scope of influences and interactions that impinge upon nurses' decision making without exploring a wide range of topics. The development of nursing and nursing education is examined to provide background context. The literature on professions, professionalism and professionalisation will

be discussed to enable an appreciation of the intra-professional dynamics within nursing and inter-professional relationships between nursing and the medical profession, the two key professions in healthcare. The problems that confront nursing in establishing itself as a robust profession are discussed in the context of the dominant position of the medical profession and the several management reorganisations that, up to now, have seemed to be to the detriment of nurses and nursing. Aspects of the sociology of knowledge will be reviewed to provide an insight of how the perceptions of individuals are crucial to the determination of their own professional realities.

Chapter 3. Conceptual Framework and Methodology. With reference to the research literature, the methods and approaches used for this study will be described. The researcher will also discuss issues about which he was aware during the research process and some reflections which occurred at various stages during the study.

Chapter 4. Looking for Patterns: Analysis of Quantitative Data. This chapter will present and analyse the data obtained from the registry database and the postal questionnaire. The data will be discussed and the preliminary findings arising from the data will be defined.

Chapter 5. Analysis of the Qualitative Data: Revelation of Motives and Opinions. The salient findings from the face-to-face interviews will be presented, the data will be discussed and the findings arising from it will be defined.

Chapter 6. Findings and Conclusions. This chapter will draw together the preliminary findings from the quantitative and qualitative stages. The overall findings and the conclusions and implications will be presented and discussed in answer to the three research aims and the questions arising from them. Unanswered questions and areas where further investigation would appear to be fruitful will be identified and discussed.

Chapter Two

Literature Review

The literature review explored a range of published sources related to the major themes of the study, namely, the nature of professions, models of professionalism, professionalisation processes, the role of professional knowledge and of preparation for practice. The literature provides theoretical context to support the researcher's interpretation and thesis about the nurses' choice of degree course. The compass of the review is necessarily broad and reflects the complex development of nursing, its inter-dependent relationship with the medical profession and the rapidly changing nature of the health services over the last three decades.

An exploration of professionalisation processes is set against changes in the wider society and the introduction of new styles of management of the public sector in which most nurses and doctors are employed. The dynamics of inter and intra-professional rivalry are examined and the mechanisms that are used by professions to expand across and to protect their boundaries through the process of occupational closure. The role of credentialing, professional governance and responses to consumerism and society's demand for enhancement of the quality of services in the context of the 'new professionalism' are also explored.

Stages in the professionalisation of nursing, embracing a number of concepts and themes outlined above, together with reforms in nursing education are then reviewed, so too are issues that continue to be of crucial importance to the future development of nursing, namely, management control of nursing, patriarchal dominance and feminist perspectives, nurses attitudes to their work, autonomy and the role of professional organisations for the continuing professional project.

Professionalisation processes occur at both the macroscopic and microscopic levels. The macroscopic (institutional) level involves organisations who are, or who represent, the interested parties: professional bodies such as the Royal

College of Nursing and the British Medical Association representing the professions, on the one hand, and 'employers' and consumer groups, on the other. Doctors' and nurses' organisations may be engaged in collaborative dialogue, for example, on securing more resources for health care, or be in conflict, on matters like inter-professional boundaries. They will also be engaged with representatives of the employers, the health trusts or the government on matters such as working conditions and remuneration.

Professionalisation processes also occur at the microscopic (individual) level in professional work places. Collectively, individuals will have a range of different degrees of awareness about macroscopic (national) issues and the extent to which they impinge upon them, if at all. The professional process at the microscopic level in individual places of work may be crucial, especially where role expansion across an inter-professional boundary is sought by one profession/occupation and resisted by another, or, when professional autonomy becomes the subject of dispute. The focus will be mainly on the microscopic level in this dissertation but important macroscopic professionalisation processes, including occupational closure will be included since it does involve individuals in their place of work.

The literature on professional socialisation, occupational choice, careers and job satisfaction was considered to be marginal and will not be included.

Models of Professionalism

Professionalism is a term used to embrace the ***behaviour*** of professions (Abbott and Meerabeau 1998:1). Profession, a sub-set of occupation, refers to specialised work by which one gains a living in an exchange economy. But it is not just any kind of work that professionals do. The kind of work they do is esoteric, complex and discretionary in character: it requires theoretical knowledge and skill, and judgement that ordinary people do not possess, may not wholly comprehend, and cannot readily evaluate (Freidson 1994: 200).

Professions are recognised in all modern societies and are accepted as being occupations that have achieved privileged status through establishing a number of

key structural and functional criteria. Sociologists have analysed professions and professionalism and have come to consider them in markedly different ways. The differences that have been discerned have been regarded as alternative theoretical approaches or perspectives, including 'Functionalism', the 'Power Approach' and the 'Process Approach' (Davies 1992). The various approaches, or which of the criteria have been considered paramount at a given time, have been responsible for the very different ways that people view professions and professionalism.

A Functionalist approach regards professions as positively beneficial to society. Parsons showed that the authority of the professions, especially in the case of medicine, was based on functional specificity, control within the professional domain and the application of universal standards based on generally altruistic intentions (Parsons 1939). Professionalism can be considered to embrace 'appealing values', if not ideals. The salient values have been identified as, acquisition of maximal knowledge and skill, sensitive empathic consideration of client needs (Halmos 1978), moral veracity, the service ethic, colleague control and tutelage (Wilding 1982), trustworthiness, integrity, autonomy and reliable standards (McIntyre 1994). It will be noted that several criteria are concerned with the maintenance of standards and quality assurance/control of the services provided by professionals to their clients. The listing of these attributes caused the functionalist model to be known also as the trait theory of professionalism.

The assimilation of an appropriate 'professional culture' is seen as a necessity and the student professional is subjected to a socialisation process from early in their training programme. Training typically takes place both in an academic institution and in a professional workplace. It is mainly in the latter that a work culture is learned, in which values, norms and expectations are communicated, standards are internalised and self-discipline becomes established.

By contrast, **Power approach** adherents contend that professions are organised to exploit their position in society and that the idealistic front of many professionals cloaks their ulterior motives (Davies 1992). Social conflict theorists in the 1970s began to take issue with the notion that professions are primarily concerned with

altruistic service-giving, claiming that professions are organised to operate in accordance with the market model in order to restrict supply, thereby strengthening demand and enabling higher prices to be charged to consumers of their services. The market model depicts each profession as a monopoly that underpins its professional power and maximises its exchange value (Larson 1977, Freidson 1994).

The power position of a profession controls the market for its services by being able to dictate terms and conditions to its clients (consumers) and to any other professions or occupations that provide 'supporting' services. The market, which ideologically is founded upon the equal rights of all individuals, is demonstrably not a free market, for, in effect, it reflects and reinforces class, gender and race divisions. The medical profession is a monopoly supplier with protectionist and elitist devices, granted or endorsed by the state, that serve to control the market and thereby to maintain its power. Professions achieve this position by pursuing strategic courses of action that amount to 'occupational closure' (Parkin 1979), in furtherance of which they employ tactical means to exclude would-be encroachers.

A market society, including the welfare society of which the National Health Service is part, can, therefore, be said to support a conspiracy to establish and maintain inequality between privileged minority professions and others. The concept of service is profession-centred rather than client-centred, primarily because clients do not have the social, pecuniary or intellectual resources to challenge the professional's definition of the situation (Eraut 1994, Davies 1996b). Professional knowledge is gained by dint of a lengthy and heroic individual effort, making knowledge a 'possession' of the autonomous individual (Davies 1996a).

The power base of the original 'strong' professions, medicine, the law and, to a lesser extent, the clergy, is derived from the monopoly of knowledge and the fact that the service that they are able to offer is in high demand, if not indispensable. These professions have thereby been in a position to negotiate a social exchange

contract with the state that, in turn, further reinforced their power. The medical profession is the epitome of this power and it is clear that the Health Acts of 1911, 1946, 1949, 1968 and 1974 contained many of the reforms modelled along the lines that doctors had lobbied for. It is equally apparent that all intended legislation that could affect doctors is previewed by the British Medical Association and, where necessary, influence is brought to bear upon the government of the day before the final drafting stage of Parliamentary Bills (Davies 1992).

As a result of extensive political negotiation with the government, with the advent of the National Health Service in 1948, doctors largely succeeded in having their monopoly interests protected, if not strengthened. Medical Committees were established in all hospitals and were the most powerful influence in management of them, a Medical Officer of Health was appointed in every local authority and family doctors remained as independent practitioners, administered, along with dental and pharmaceutical services, by Executive Councils.

Nursing organisations were then politically immature and had very little influence in furthering the interest of nurses. What little power nurses had was at local hospital level through the office of the Matron and the extent of this power was limited and could be curtailed through pressure exerted through the employer, the Hospital Management Committee (HMC). Most HMCs were strongly influenced by the pre-dominant role-holders, the Medical Superintendent and the Hospital Secretary who were both likely to have their reasons for restricting the power of the Matron.

The **Process approach** is a school of thought that acknowledges that neither the altruistic model nor the power model exists in its true form but rather that they can be considered to be opposite sides of the coin. Therefore elements of both are compatible and can be recognised when a profession is analysed. This writer believes that any profession lies somewhere between the two poles of 'altruism' and 'exploitive self-interest' and there is likely to be some movement along the 'continuum' from time to time. The strong professions that have been established

for many years undertake less movement than occupations that aspire to full professional status. Newer occupational aspirants for professionalisation are necessarily oriented towards change and mobility in contrast to the older status professions that are primarily concerned with stability and security in maintaining their monopolies (Freidson 1994: 227). Aspirants to professional status will engage in positive efforts to improve their image to the public and politicians in order to convince them of their uniqueness, credibility and worthiness to be elevated to the ranks of the professions.

The process approach is a strategy and the employment of a number of tactics whereby an occupational group moves towards attaining 'occupational self-government' or autonomy (Hugman 1998:181). The process by which an occupational group strives to gain its end will involve its members to varying extents. The leadership will be immersed in employing the formal articulation of its case in the appropriate arenas of power but rank and file members may have a small local and informal role, if at all. The strength of the claim is likely to be dependent on the cohesiveness of the occupation's membership and its size. The success or otherwise of the professionalisation process can be influenced by other professions if they resist the aspirant occupation's moves and by significant patrons, especially by a monopoly or large-scale employers. In the case of nursing, resistance against encroachment into the medical domain by doctors is firm. The state, as the major employer, has a vested interest in exerting influence to limit the strength of nursing in securing higher financial rewards for nurses, since the nursing paybill accounts for 40% of NHS expenditure.

Professional Knowledge

The importance of a body of professional knowledge and skills and the rigour of the educational process for transmitting it in determining the status of a profession features widely in the literature of professions. Professions are knowledge-based groups, where knowledge and status are closely aligned (Torstendahl 1990, Macdonald 1995). Some writers have differentiated between technical (scientific) and practical knowledge (Eraut 1988, Pearson 1989, Hoyle and John 1995). In medicine, the foundation of scientific knowledge largely comprises biology,

chemistry, physiology and pharmacology. This technical knowledge is explicit, replicable and capable of written codification: it resides in texts and learned journals (Eraut 1988, Hoyle and John 1995: 46).

But technical knowledge is necessarily combined with practical (experiential) knowledge in clinical practice. An expanding repertoire of clinical knowledge is gained and refined through continuing practice and upon reflection about the experiences (Schon 1983). This implicit and intuitive practical knowledge is heavily relied upon in subsequent situations for diagnosis and prescription of treatment.

How and where knowledge and skills are acquired have an influence on the status of a profession. The status professions have a long history of being educated within the higher education sector and enjoy a prestigious presence within the universities that undertake their professional preparation. Medical education and skills training is established in the older prestigious universities and associated 'teaching' hospitals, serving to perpetuate the high status of medicine. Lower professions and aspirant occupations, not unnaturally, take steps to establish themselves by developing a stronger knowledge base and a higher and more prestigious award leading to entry and authority to practise.

Medicine has demonstrably had a strong foundation of scientific knowledge to underpin it and, indeed is making substantial advances at the present time through new discoveries and technologies, whereas nursing has lacked a rigorous knowledge base. Nursing has relied on a watered down range of life sciences espoused by medicine and, from the 1960s some applied social sciences, especially psychology and sociology with some anthropology. There is as yet very scant nursing knowledge derived from research although 'evidence-based' care is being increasingly encouraged as a basis for practice (Kitson et al 1996). The journal *Evidence Based Nursing* was founded in 1997 expressly to publish nursing research with positive findings intended for use by practising nurses.

Nursing research findings require critical evaluation before they can be applied in situations with significantly different sets of variables to those in which the

research was undertaken. Evaluation and appropriate decision-making relies upon a more substantial underpinning of theoretical knowledge than is contained on pre-registration courses. There is a continuing problem concerning the inadequate knowledge base of the majority of nurses since comparatively few have been educated to degree level.

While practice is an essential part of any profession and its training, there is a considerable body of opinion amongst nurses that believes additional theoretical study is either not necessary or its importance is underrated. This belief is often accompanied by overt anti-education attitudes (Salvage 1985: 77, Mackay 1989: 81). This devaluation of the knowledge aspect, casts doubts on the standing of nursing as a profession (Macdonald 1995:134).

Professionalisation

Professionalisation has been defined in differing ways as: 'the organisation of a profession with the emergence of an elite who assume positions of power on behalf of its members and represent their interests in an attempt to translate one order of scarce resources - special knowledge and skills - into another - social and economic rewards (Larson 1977: xvii); 'a collective strategy to enhance the rewards of members of a profession' (Walby and Greenwell 1994: 2); 'the process by which an original occupation, usually but not always by virtue of making a claim to special esoteric competence and concern for its quality of work and its benefits to society, obtains the exclusive right to perform a particular kind of work, control training for and access to it, and control the right of determining and evaluating the way work is performed' (Freidson 1994: 62). Some have argued that 'this self-interested strategy' that espouses the power model should not be put before the wider social responsibility that professions should aspire to, namely, provision of service to the public and ensuring social justice embracing the altruistic model (Goodson and Hargreaves 119: 9).

Other writers have identified an intermediate stage along the path to becoming a profession that is not aligned to any particular model, 'a process through which certain professions pass, 'the end state being a profession' (Lorentzon 1992:2);

'professionalisation is thus the process by which a semi-profession increasingly meets the alleged criteria of a full profession" (Hoyle and John 1995: 16).

Professionalisation is complex and dynamic, it is neither automatic nor linear, regardless of the perceived attributes and worthiness of aspirant occupations (Abbott 1988). It is worth striving for because the achievement of professional status leads to higher cultural, social and economic rewards and increased political power collectively and for its individual members.

Society has different ways of valuing professions and occupations by making comparisons based on perceptions of worth. The *status* that it awards is relatively formalised and represents the rank or standing of one in relation to others. Status has rewards and privileges attached and, in the case of professions and occupations, these are social and economic. Comparing medicine and nursing, medicine is high status, whereas nursing is low. Esteem also denotes high regard and respect but, compared to status it is not formally endowed, it can be more easily disturbed and does not confer tangible economic benefits. Generally nurses are held in high esteem but have a comparatively low status.

Professionalisation and the development of a position of real power is also influenced by the total number of professionals represented (Begun and Lippincott 1993). The higher the ratio of clients to professionals, the more influential is the profession. The top echelon of professions, consisting of medicine, the law and the clergy, typically provide services for 2000 or more of the population. This, together with preparation for practice undertaken within the university sector and being sociologically located within the upper middle class, confers both a scarcity value and a tendency to attract respect.

Conversely, nurses, social workers and teachers are considerably larger in numbers, they have a smaller ratio of practitioners to clients, do not have a long history of being educated within the university sector, conventionally fall within the lower middle class and are frequently recruited from working class backgrounds and are predominantly female. White (1982) in discussing elitism as

a criterion for becoming a profession, made a telling comment, 'the 500,000 nurses employed in the UK will never become an elite'. This gives a ratio of 1 nurse to every 115 of the population - or eighteen times as many nurses as doctors. Freidson (1983) differentiates the status professions; medicine, the law, the clergy and university teaching from the 'occupational' professions that have developed more recently. Members of status professions are looked up to in recognition of their high social status and not merely for the job they do. Doctor, lawyer and minister of religion are socially valued labels as well as occupational descriptors, whereas nurse, schoolteacher and social worker are occupations that hold a comparatively low status among professions.

Three different elements can be analytically distinguished in progress to professionalisation. The initial credentialing process, whereby an occupation acquires knowledge and skills through education (preferably in institutions of higher education), admittance after examination, and the granting of a licence to practice, in many cases endorsed by the state (Murphy 1988, Macdonald 1995, Witz 1992). The second is the acquisition and exploitation of political, social and economic power through exclusion of laypersons, the making of arrangements for the division of labour, defining the scope of professional practice, the setting of standards and controlling rights of access and discharge, and securing financial rewards. Thirdly, is the development of a collective consciousness and organisation into a collective representation of interests and approval of strategies (Siegrist 1990: 177). The first of these functions comes under the aegis of a statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting for these professions. The last two functions are generally undertaken by a professional organisation such as the Royal College of Nursing.

Deprofessionalisation and the Effects of New Public Management

It has been asserted that the peak of professionalism has passed with the demise of the traditional bureaucracy, under which 'professionalism contributed a further framework of accountability within which expertise and knowledge could be harnessed to welfare needs and so be reconciled to a wider public interest' (Laffin 1998). The traditional bureaucracy was more of a control mechanism that allowed

a certain freedom, rather than an accountability system that confronted professional practitioners and forced compliance to management edicts.

The 'new public management', incubated by the new right in the Thatcher years, was introduced from the early 1980s with the purpose of exacting tighter managerial control over public sector institutions to improve efficiency and extract economies. As the great majority of professionals are employed within these institutions they consequently came under pressure to amend their ways of working. Other names have been applied to the new public management (NPM), namely 'neo-bureaucracy' and 'post-bureaucratic management' (Laffin 1998). This writer will use NPM where appropriate.

Changes that have occurred that are perceived to have been disadvantageous to professional ways of working are referred to as part of the process of deprofesssionalisation. Review of the literature on deprofessionalisation reveals three types of change: deskilling, erosion of professional knowledge and trust, and proletarianisation (Storch and Stinson 1988, Murphy 1990).

Deskilling occurs when a number of tasks originally solely within the remit of a professional become distributed to lower status workers to perform. This results in fragmentation of professional work, (usually to lower paid workers), rules for the redistribution of labour are introduced, roles are more narrowly defined and the professional suffers an erosion of autonomy. Most professionals affected, not least those in the health services, express concern about increased pressure of work and loss of control over the factors responsible for it.

Deprofessionalisation through erosion of knowledge and trust (Laffin 1998) can occur due to the greater accessibility to knowledge that has recently become available through improvements in communication and modern media. Previously, professional knowledge was almost solely held by the professionals themselves who ensured limited access by outsiders as a deliberate strategy, recognising that 'knowledge is power'. Higher standards of education, greater expectations in the standards of professional services and increased assertiveness

have narrowed the knowledge gap and caused professional practice to be challenged. Increasingly, citizens and clients have become organised by the setting up of interest and pressure groups forcing professional practitioners to review their actions (Bertilsson 1990: 130)

The term proletarianisation stems from Marxist ideology. Professionals in particular and credentialed groups in general, were considered to form a ruling class with power based on control of knowledge, rather than the means of production, and whose income came from fees levied for direct services to clients. The loss of autonomy and the employment of professionals by institutions are viewed as a loss of status and privilege that is claimed to be tantamount to returning them to the proletariat. The Marxist argument is partially dependent upon capitalist conspiracy theory and has been eruditely demolished by Murphy (1990). Other writers have examined the concept of proletarianisation and found it unhelpful (Hoyle and John 1998). The term will not be used subsequently here.

Politicians and managers had an agenda to control professionals through NPM by reducing their institutional power as much as possible while avoiding the sacred cow of autonomy over direct intervention with the client – professionals 'on tap' rather than 'on top' (Pollitt 1993). They approached this by adopting policies aimed at defining the power relationships between professionals and managers in favour of managers (Bottery 1998: 7). The main weapon against professionals was the imposition of market tactics that not only meant external competition between hospitals and trusts but internally between fellow professionals in their quest for scarce resources. This also entailed devolution of responsibility for more management activity at unit level, causing conflicting demands between care of clients 'the real job' and more 'paperwork'. Nurses, in particular, wanted less paperwork in order to spend more time with patients Bottery 1998: 141).

In general, NPM engendered two conflicting cultures, a professional culture in which its members felt embattled and on the losing end and a management culture in which managers also felt embattled but that they had gained ground. Some hospitals made attempts to reconcile the two cultures but fundamental gaps

remained (Bottery 1998). For professionals in the health service, the outcome of free market proposals, of centralist directives and management imposition caused an acquisition of new values by habit rather more than by choice. There was a values conflict between 'quantity' and 'quality'. The problem for professionals being that quality became increasingly to be decided by managerial values, not professional values, with justice, equity, community social cohesion and citizenship being paid no more than lip-service (Bottery 1998: 154).

NPM, therefore, was partly responsible for deprofessionalisation through imposing new expectations and requirements upon professional practice, circumscribing professional claims to cognitive superiority, diluting the proportion of professional practitioners, and requiring more work to be done per unit of resource (Laffin 1998). These factors are applicable to nursing, especially with regard to registered nurses. The number of nurses in management has declined with loss of a voice at top management level, career and pay structures have been changed with fewer nurses assigned to grades equivalent to the 'old' management grades, fewer promotions are occurring, health care assistants have taken over a significant amount of patient care, work pressures have risen to the extent of there being insufficient time to maintain care at the desired standard.

Intra-Professional and Inter-Professional Rivalry

Process adherents acknowledge the various rivalries within and between occupational groups and the struggles for acceptance and dominance that are inevitable. Doubts are cast about claims that professions are composed of homogenous groups and it is common to find differences in the standing and 'pecking order' within many professions. In the case of the medical profession, there is a certain rivalry between general practitioners and hospital consultants and between the different specialities among hospital consultants. Surgeons in the sought after specialities, who command greater resources and higher salaries, are likely to consider themselves more important than their counterparts in geriatrics and mental illness (Davies 1992).

The areas within healthcare, which enjoy the greatest prestige, are where medical interventions have the greatest impact on the recovery of patients – the cure factor. The relative prestige of a speciality declines where the cure factor is lessened and the care factor is greater. The level of funding has been found to be roughly proportional to the level of prestige and also to the attractiveness of nurses to work in the specialty (Mackay 1989).

For much of this century community nurses enjoyed a higher status than hospital nurses. This was largely derived from their mandatory post-registration courses at higher education level that qualified them for their practice, and partly due to the higher status that doctors, in particular, regarded them as having. Hospital nurses who work in high technology units, like Intensive Care and Accident and Emergency also tend to regard themselves as having a higher status than nurses who work on 'ordinary' general wards, who, in turn, consider themselves to have a higher status than nurses on geriatric wards.

Differences have also been found among nurses in their attitudes to power and control of nursing activity in the workplace. Research by White found that nursing is a plural society with three distinguishable sub-groups; *managers*, whose primary need is to control their nursing staff, to maintain nursing cover (for patient care) within the constraints of their budgets, and to uphold the status quo. Secondly, *generalists* (or functionalists) who gain satisfaction from their work and are content to work within the hierarchy supervised by nurse managers and who are also satisfied by the status quo. The third group, the *specialists* or 'professionally-minded' tended to look for professional authority based on higher education and a specialised knowledge base. They tended to challenge the status quo and the vertical power structure of nursing (White 1988).

Since White's research was undertaken, the influence and the number of nurse managers has declined and the statutory body advocated that nurses assume greater autonomy for their own decisions (UKCC 1992). These factors are potentially significant in shaping nurses attitudes and should lead them to take increasing responsibility for their work.

The central issue of professional power lies in the control of work by the professional workers themselves, rather than by control by consumers in an open market or by functionaries of a centrally planned or administered firm or state (Freidson 1994: 32). There is a continuing struggle between the medical profession and the minor hospital professions, especially nursing, for control and delegation of work. There is a tendency for the profession at the top of the hierarchy to discover or claim new areas of work that are considered to be more prestigious and for work at the less attractive end of the spectrum to be cast off and handed down to the lower level profession or occupation. Occupations lower in the hierarchy often seek to acquire work from a group that is above them in a hierarchy. Both the higher and the lower occupations adopt strategies to further their own ends and these will be discussed later in the section on occupational closure.

Doctors not only control their own work carried out directly for their patients, but also the work of others whose raison d'être is to support the medical and health industries. It is doctors who have established a powerful and rapidly growing body of knowledge, who have acquired the legal authority for admitting clients (patients) to the health service, for ordering investigations and tests, for prescribing treatment and for surgical intervention and thereby possess the power to command resources. They are firmly entrenched in the role of 'gatekeeper' and consequently control the work and scope of those who exist to support them.

There is a shifting professional boundary between doctors and nurses that has to be frequently negotiated; examples being, intravenous interventions, respiratory management in Intensive Care Units and wound management. It is a boundary along which territorial disputes are sometimes conducted, highlighting that professional organisation of the different professions is not compatible with the notion of inter-professional teamwork (Walby and Greenwell 1994). However, in many cases doctors and nurses work in harmony with few, if any, disputes when no serious challenges are made on medical hegemony.

Doctors exercise substantial power over the healthcare domain. Nurses, medical laboratory technicians and other professions supplementary to medicine have limited choice over how and where their services are given and little power over how they will shape their conditions of service. Since there is no possibility of progression from these supplementary or semi-professions to full professions, to become medical doctors, they are frozen into a caste-like position of subservience (Etzioni 1969).

The Cumberlege Report (DHSS 1986) made a case for community nurses being able to prescribe certain medicines, a proposal that was strongly endorsed by nursing organisations, especially the Royal College of Nursing. The medical profession put up resistance whenever they perceive a significant attempt at encroachment into the medical domain. A recent example concerned doctors losing their exclusive right to prescribe, against nurses in particular but also against pharmacists being able to prescribe or sell what are currently 'prescription-only' drugs (BMJ 1988: 226, Beecham 1990, GMC 1992). The defence of their exclusive right was based on a combination of possession of greater knowledge of drugs in clinical practice, including side effects and idiosyncratic reactions between drugs in the case of multiple drug use, and *ultimate clinical* responsibility for *their patients.*

The inter-professional disputes between the medical and nursing professions are mainly concerned with the authority to undertake roles and tasks in the treatment and care of clients but the common theme of all disputes is control of the health agenda by the medical profession.

Hospital and Community Nursing Compared

Over the last decade the percentage of qualified nurses employed in hospitals compared to the community, (in whole time equivalents –WTE), has fallen from 82.47% in 1990 to 80.41% in 1999. In 1999, the WTE numbers for the two sectors were: hospital 201,103, community 48,987 (DHSS 1990b, DoH 1999). The differences in nurse employment between the two sectors are not merely quantitative, there are a number of qualitative differences too. There are

differences in working practices, in philosophical orientation to the work and in the attitude of staff towards the conditions that prevail in hospital, compared to community settings.

Nursing work in hospitals tends to be quite closely controlled and routinised, with larger numbers of people working in teams that involve frequent multi-disciplinary interactions. Hospital nurses are constantly aware of being within a strong hierarchical structure with clearly defined relationships that are re-inforced daily. Compared to the community, hospitals have a much faster throughput of patients who must be regarded as temporary role incumbents. There is a shorter length of time for the development of nurse-patient relationships. Hospital nurses have high intensity workloads and patients are heavily dependent during the first few days after admission and after their operations. Generally, individual nurses have very little freedom to exercise control over their workloads and the nature, style, pace and timing of their work, even though some individuals may exercise autonomy for making decisions about the care of 'their' patients.

Community nursing embraces a number of different roles and specialties, the main ones being; District Nurses, Health Visitors, Occupational Health Nurses, Practice Nurses - who work in local Health Centres and directly with General medical Practitioners (GPs) and, more recently, Nurse Practitioners. Nurse Practitioners have been trained to a higher level; they have more autonomy than Practice Nurses and may treat patients without referral to their GPs.

Community nurses usually work alone or in small teams with greater continuity, have greater control over their work pattern, have patients over longer periods and are less likely to be in, or feel they are in, a hierarchy. This writer has a clear anecdotal impression that many nurses who take up community posts have done so consciously to escape from hospital work.

Occupational Closure

Inter and intra-professional boundaries are subject to attack by professions or factions within a profession seeking to enlarge their field of work. Conversely,

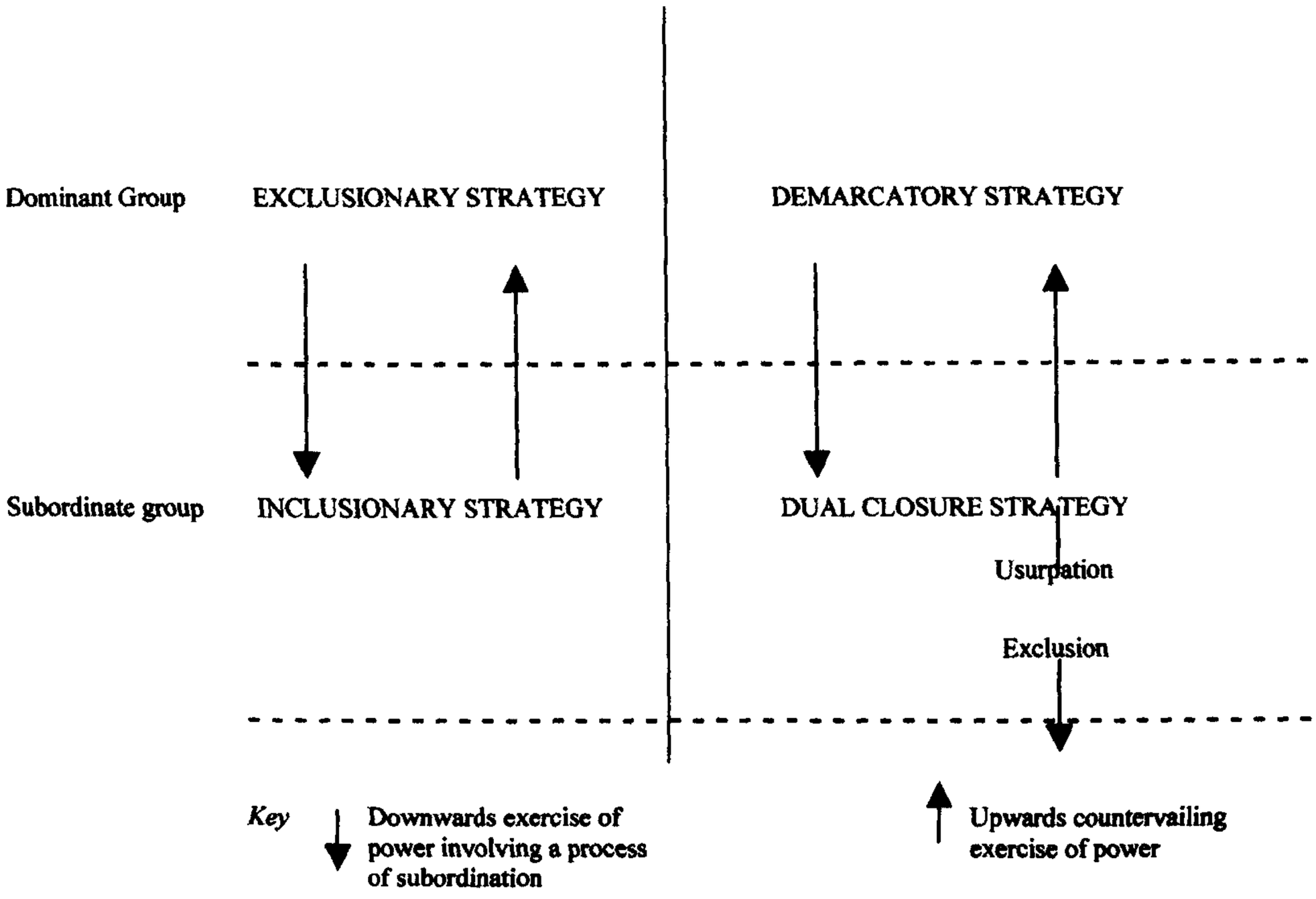
those who feel under such an attack will mount a defence to prevent usurpation by the invaders. The power relationships, strategies and tactics employed were investigated by neo-Weberian writers, (Parkin 1979, Freidson 1983, Witz 1990), among others, who developed the concept of ***occupational closure***.

Recognising that the generic concept of professions is also a gendered one, Witz decided to utilise Freidson's (1983) approach and abandon any generic concept of profession in order to attempt to redefine the sociology of professions through the use of historical case studies, whereby each profession would be treated as a separate 'professional project'. A professional project is a strategy adopted by a profession to achieve an occupational monopoly over the provision of certain skills and competencies in a market for services (Freidson 1983). Professional projects consist of strategic courses of action which take the form of occupational closure strategies and which employ distinctive tactical means in pursuit of the strategic aim of the closure. The primary means of a profession acquiring the monopoly position is through the granting to it of state licensure, amounting to educational and occupational credentialing.

At a given point in time it is likely that any profession will need to maintain or improve its present market position. Maintenance will require defensive tactics, while expansion to achieve greater power will probably depend upon aggressive use of existing power. Some writers about the medical-nursing occupational boundary (MacGuire 1980 and Allen 1998), drew a distinction between role *expansion,* where new work has been undertaken within the undisputed nursing domain, and role *extension,* where nurses have acquired new work from the medical domain, with or without medical opposition. The concept of inclusionary occupational closure concerns attempts at role extension against resistance.

Parkin (1979), constructed a four-fold conceptual model of 'Strategies of Occupational Closure' that is depicted in figure 2.1, as developed by Witz (1990).

Figure 2.1 Strategies of Occupational Closure: a conceptual model
(from Witz, 1990)



The model demonstrates the relationships between the strategies of exclusionary, inclusionary, demarcatory and dual closure. The model assumes the presence of a dominant and a subordinate group, both providing services within a labour market, at least some of which compete. Within the health field, the dominant group are medical doctors and the subordinate group can be taken to be nurses.

The left hand side of the figure has just these two groups but on the right hand side, the middle group is confronting a subordinate contender attempting to gain ground also. In the health field this group would be Health Care Assistants. The dominant group to defend its position uses exclusionary and demarcatory strategies.

Occupational closure and other forms of professional project are usually taken to be, or are presented, as occurring at the macroscopic (institutional) level between national organisations representing the interested parties. However, the macroscopic process is rarely conducted *in vacuo* but should be considered as a formalisation of professionalisation activity by individuals at the microscopic level in their places of work, as Witz demonstrates in her analysis of work

expansion of nurses on Nursing Development Units (Witz 1994). Therefore, where behaviour and/or comments of individuals suggest that they are engaged in the process of professionalisation activity, such as occupational closure, in their places of work, it will be alluded to later in this dissertation

Credentialing

The path to professional acceptance is now well worn and necessarily progresses through several incremental stages. The initial criteria must comprise a defined area of work and a range of services for provision to clients, a minimum repertoire of skills and a field of knowledge deemed to be essential for sound understanding of the work. The next important process is to define the appropriate training and preparation for admission and to get this accepted by the social, political and educational authorities. Eraut (1994) identifies the modes of training and preparation for occupations seeking professional credentialing as:

> * *a period of pupillage or internship,* during which time students spend a significant amount of time (up to five years) learning their craft from an expert;
> * *enrolment in a 'professional college'* outside the higher education system;
> * *a qualifying examination,* normally set by a qualifying association for the occupation;
> * a *period of relevant study at a college, polytechnic or university* leading to a recognised academic qualification;
> * *the collection of evidence of practical competence* in the form of a logbook or portfolio. (Eraut 1994, my italics)

A point of issue in the case of nursing is whether it has achieved full professional status, whether it remains a semi-profession, and if so, has its journey to enhance its status been brought to a permanent stop - that is, has the process of professionalisation ceased? Much of the literature that discusses the issue of the professional status of nursing suggests that nursing has achieved most of the trappings of a profession but is, and it is likely to remain, subservient to the medical profession, being trapped by its inability to break free of this restraint.

Numerous sociologists have examined the occupation of nursing and compared it with other occupations, including those classified as strong professions, and have drawn differing conclusions. Early this century, criteria were identified that were used as standards of comparison to determine which occupations fitted the mould for inclusion in a list of professions. These early sociologists, such as Flexner, used the 'trait' theory to analyse the existing undisputed professions, especially medicine and the law, to attempt to elicit objective means to classify other occupations as professions or 'non-professions'. Professions were said to be characterised as being basically intellectual, learned in nature with a distinct body of knowledge, practical as well as theoretical, possessing skills and techniques that can be taught through educational discipline; highly responsible; well organised internally and motivated by altruism (Flexner 1915).

Many later writers produced their own lists of these criteria or characteristics that vary to some extent one from another. Larson (1977) identified the following characteristics of the professional phenomenon as; professional association, cognitive base, institutionalised training, licensing, work autonomy, colleague control and code of ethics, possession of a skill based on theoretical knowledge and testing of competence of members.

The occupations of nursing and remedial therapies received a lot of attention from Etzioni (1969) and Katz (1969). They both found that nursing fulfilled some of the criteria for classification as a profession but not others. Nursing and the remedial therapies were found wanting in respect of two criteria. Firstly, they could not lay claim to an independent and robust scientific knowledge base and they were predominantly skills-based. Secondly, they had not achieved independent occupational self-government. They were declared to be semi-professions (Etzioni 1969).

As a result of a review of literature relating to the caring professions, Hugman (1991), rejected trait theory as a means of distinguishing professions from other occupations and he also rejected the notion of semi-professions because of its

dependence on trait theory. He argued that organised caring professions that are based on a '*commitment* towards caring for other persons or ideas' should be considered to be professions, given the following qualification: 'commitment is expressed through the enabling of the other persons (patients in the case of nurses) to achieve their maximum potential'. Hugman concluded that there was a distinction between professions such as medicine, the law and the clergy, that were male-oriented and that cared *about* and professions including nursing and social work, that were female-oriented, that cared *for* clients. Caring for, depends upon emotional as well as intellectual commitment and has a tending and nurturing function predicated on feminine values. Hugman contends that nursing should be regarded as a profession based on these qualities and the moral claim that they imply (Hugman 1991:9-12). This writer accepts this argument as a basis for considering nursing to be a profession and future reference to this effect is based upon this acceptance.

New Professionalism and Quality of Service

According to Hoyle (1974), there are two strands in the process whereby a semi-profession increasingly meets the alleged criteria for a full profession. One element is the process of meeting the institutional requirements, strengthening the boundary, increasing credential requirements and maintaining a self-governing body. The second strand is improving the quality of the service provided, through improving the skills and knowledge of the practitioners. Hoyle and John refer to this as 'professionality', embracing knowledge, skills, values and behaviours exercised on behalf of clients (Hoyle and John 1995: 16).

Professionality can be recognised in the professionalisation project of nursing, focusing on establishing quality in practice. The drive for quality was almost universal throughout the western world as 'consumerism' across the entire range of goods and services. In nursing it embraced the development of the nursing process and nursing models, quality assurance and standard setting, specialisation of nursing roles and clinical areas and associated competency-based training, and higher levels of continuing education and training. This theme will be elaborated upon in the next section in the discussion about 'new nursing'.

The Professionalisation of Nursing

The professionalisation of nursing has been a campaign waged against the dominance of the medical profession and management regimes within the health service to establish a distinct and autonomous sphere of competence within the health division of labour. This has been relatively unsuccessful, not so much due to the efforts of opposing forces per se but because the root problem *for* nursing has been, and continues to be that *of* gender (Witz 1994: 23 *emphasis in the original*). She believes that the process that nursing has been involved in for over a century is better termed an 'occupational strategy' or 'professional project', rather than professionalisation, due to the lengthy time span and discontinuity of effort and progress (Witz 1994: 25).

Two active stages can be identified in the process separated by a long interval of comparative inactivity or lack of progress. The first stage lasting over 20 years entailed both credentialistic and legalistic tactics. Mrs Bedford Fenwick and her supporters strived for better education for nurses and examinations leading to credentialing and registration with a single portal of entry through legislation. Their success was limited to the setting up in 1919 of a register of nurses but with multiple portals of entry and, in spite of the statutory body being given responsibility for education, improvements in nurse education over the next seven decades were only marginal and incremental.

A long period of abeyance lasting over 40 years followed where activity by statutory bodies and professional associations was somewhat feeble with only a few minor changes being made to nursing education. A comparative setback was the formalisation of assistant nurse training in 1946 and the establishment of separate arrangements for State Enrolled Nurses a few years later. The introduction of these second level nurses was an expediency borne of a shortage of registered nurses that was later exploited by the NHS as a cheaper alternative to them.

The second active stage in professionalisation, which later became known as 'new nursing', started in the 1960s initially in the USA with the introduction of the 'nursing process' and went on to include nursing models, nursing theory, and a clinical career structure. These innovations were accompanied by a philosophical shift as a basis for nursing education and practice from the medical model to one of holistic patient-centred nursing based on health rather than illness. These new nursing changes paralleled 'new professionalism' that was occurring in many other professions/occupations, of which teaching is perhaps the clearest example (Hoyle 1995, Hoyle and John 1998).

This second stage of professionalisation in the form of the new nursing is presently continuing although progress is painstakingly slow, if it has not actually ceased. The components of the new nursing are now elaborated upon.

Prior to the advent of the new nursing, nursing practice was based largely on intuition, instinct and empathy, rather than objectively derived facts (Aggleton and Chambers 1986). Techniques and procedures were passed down through dint of the apprenticeship system of training without recourse to sound theory. The nursing care given was poorly documented, if at all. Over the 1960s and 70s a new set of requirements was established, namely, a more systematic approach to nursing care, proven levels of competence in techniques, and research to elicit the efficacy of alternative approaches, methods and treatments (Henderson 1966, Mayers 1972, Yura and Walsh 1967). The basic thrust was to make nursing care more objective and transparent to allow evaluation and to exact accountability for actions of individuals.

The 'nursing process', a decision-making model derived from systems theory, was developed in the United States of America in the mid 1960s. It is a systematic approach to care consisting of four phases; diagnosis of nursing needs, planning care to meet the needs, undertaking nursing interventions, and evaluation of the results of the interventions. The process is carried out for individual patients with their collaboration where possible, with particular attention being paid to physical, psychological and behavioural needs. Documentary recording of each stage is

undertaken to enable progress to be followed, for exacting accountability and assessing the quality of care delivered (Aggleton and Chambers 1986: 2-4).

Having developed a decision process for nursing, it was realised that a conceptual model of nursing care was necessary for a clearer understanding about people, their environments and their nursing needs, using concepts based mainly on the sciences and practical methodologies such as counselling. Several models of nursing were introduced, each comprising its own combination of concepts, examples being Henderson (1972), Roper et al (1980), Roy (1980).

The abstract models paved the way for the development of nursing theory. In contrast to nursing models, nursing theory employs *specific* concepts and their relationships and can explain and predict phenomena and outcomes. Theory building depends on research to address four central elements in nursing; the person receiving care, the environments in which the person lives, the nature of the health-illness continuum at the time the care is being given and the type of activity deemed appropriate to secure a return to relative well-being (Fawcett 1978 and 1984).

Competency-based training became established as a component of a consumer-focused effort to boost the quality of services from the early 1970s, accelerating over the next three decades. Its development, therefore, roughly paralleled the approaches to nursing just discussed. Competency-based training projects in, or affecting nursing and health care included; the setting up of the Joint Board of Clinical Nursing Studies in 1970, with the remit of providing and monitoring specialist clinical courses with awards for proven competency in practice, the Framework for Continuing Professional Education for Nurses, Midwives and Health Visitors (ENB 1991), and The Post-registration, Education and Practice Project (UKCC 1995). (The JBCNS was later merged with other nursing bodies to form the four National Boards for Nursing, Midwifery and Health Visiting).

The founding of the National Council for Vocational Qualifications which set standards and awarded NVQs for many occupations/professions was important to

nursing, not least because it validated the work undertaken by health care assistants who support nurses by providing a significant amount of patient care. NVQs are awarded at four levels from basic manual skills at level 1 to mastery of complex skills with degree equivalent intellectual content at level 4.

What is arguably the boldest attempt in the professionalisation of nursing was the advent of Nursing Development Units (NDUs) – small wards the beds in which were under the control of nurses and where doctors, when required in emergencies, attended upon the request of nurses. There was a 'primary nurse' for each patient, analogous to the named medical consultant elsewhere. Nurses undertook the gatekeeper role of admitting patients, deciding all care and treatment except where a doctor was legally required to prescribe, and deciding upon discharge.

The primary nurse role in NDUs is complementary to that of the patient, rather than subservient to that of the doctor. This was a significant enhancement of the nursing role with real autonomy. The best known was the Oxford NDU, which functioned between 1986 and 1989. It consisted of 16 beds and represented the 'contemporary ideology of nursing in action' (Pearson 1988: 131). This new ideology divorced caring from being an adjunct of curing under medical supervision and insodoing empowered nurses and patients by the adoption of consumerist values. The primary nurses were called nurse practitioners and they were supported by other qualified 'associate nurses' and non-nurse care assistants.

Doctors opposed the presence of the NDU because primary nursing in practice redefined the traditional division of labour between doctors and nurses by an exclusive nurse practitioner-patient relationship. Opposition by doctors increased throughout the period the unit was open on the grounds that it was 'medically unsound. They refused to refer patients and were reluctant to provide emergency cover (Witz 1992: 36).

A few other units named NDUs were set up but none of these functioned with nurses performing an enhanced role. They undertook extended roles, performing

procedures that were traditionally in the medical domain under looser medical supervision than is customary. These did not, therefore, contribute much to increasing nursing autonomy.

The position of nursing with regard to extending the depth of knowledge and applying it to practice is an important consideration. This is likely to remain a key determinant of a profession. Indeed, Witz believes that the success or otherwise of nurses' occupational strategy hinges upon knowledge content (Witz 1992: 38). In the UK a significant step forward in the professional project has been the adoption of the Project 2000 reform of pre-registration nurse education, shifting from an apprenticeship to an education-based preparation for practice. This is one of two crucial factors and will prove to be the easier. The second is the creation of a *sufficient* body of knowledge of nursing derived from research to be used to support the move to evidence-based nursing. The improved education that will enable nurses to be 'knowledgeable doers', a core aim of Project 2000, is still some way off. Project 2000 courses will only provide a basis for this to become reality; much more is yet to be achieved. The Project 2000 nurse education concept is discussed in the next section, together with a brief historical outline of the earlier training scheme and post-registration education to provide contextual background.

Nurse Training and the Education Process

Pre-registration nurse training was beset by problems and was considered to be unsatisfactory in several respects for most of the time since modern nursing was instigated in 1860. The main issues were low entry standards, poor recruitment and retention, inadequate time available for the educational process, too much time spent by trainees providing direct patient care, schools of nursing too dependent on health authorities for resourcing, a mismatch between the theoretical content of courses and the practical experience and low educational attainment on the courses, which were pitched at a sub-higher education level. Over the decades numerous committees were set up to investigate these problems and to suggest solutions, among the most significant were the Wood Report (HMSO 1947) and

the Briggs Report (1972). However, only minor changes were made during the period that the General Nursing Councils' had responsibility for nurse training.

The Nurses, Midwives and Health Visitors Act 1979 was a landmark in the statutory control of the professions named in the Act and for the development of new forms of education. For the first time all members of the 'family' of nursing professions were to be brought under the same statutory bodies, the United Kingdom Central Council of Nursing, Midwifery and Health Visiting (UKCC), and the National Boards of Nursing, Midwifery and Health Visiting, one for each of the countries of the UK

A single professional register divided into general and specialist parts was set up. It is a live register, with five-year periodic re-registration, rather than the 'once-for-life' registration of most of the previous statutory bodies. The former registers were known to have included large numbers of non-practising people, both living and dead; since the main way that names were removed was upon request and few nurses or relatives of the deceased bothered to do so.

Around fifteen years ago, it had become increasingly evident that a number a radical changes were needed to pre-registration courses for nurses. The principal reasons were that student nurses were providing around 60% of the total service to patients and scant attention was given to providing educational experience based upon their training needs. The key changes that were proposed were; to elevate the educational level of the standard IPE courses from sub-diploma and pitch them within the HE level; to free student nurses from the requirement for them to provide productive patient care; to arrange their practical experience to fit defined educational objectives; and to revise the syllabus to focus upon principles of nursing rather than a watered down version based upon a medical model.

A movement became established whose adherents advocated that nursing should be based upon concepts of health and that people (patients/clients) should be regarded holistically as capable human beings who should be involved as fully as possible in responsible decision making about their conditions, treatment and care.

The social and behavioural science content of the courses was markedly increased and concepts of health, health education and health promotion with the emphasis shifted towards prevention of, rather than cure of, disease and illness became the main conceptual framework of the new curriculum for pre-registration nursing education that was to be known as Project 2000 (UKCC 1986).

Pre-registration Nursing Education and Training

Prior to 1989, when the first pilot schemes for the reform of nursing education were started, 98 percent of nursing education was within NHS Schools of Nursing (RCN 1985). Each School of Nursing was managed by a Director of Nurse Education was, in most cases, accountable to a District Health Authority (DHA). The teaching staff was paid for by the National Board but the buildings and the student nurses training allowances were paid by the DHA 'in exchange' for the students providing nursing services to patients (Meerabeau 1998: 84). Between 26 and 30 weeks of the 156-week (3 year) training period was spent learning the theory of nursing and supporting academic disciplines. The remainder, less 6 weeks each year for annual leave, was allotted to work experience in clinical areas. Thus, 35 weeks a year was spent learning nursing practice under supervision. For most of these 35 weeks, that is, excluding a few weeks when students were supernumerary in the community and on certain highly specialised units, the hospital service depended upon them providing nursing care.

The Project 2000 scheme of nurse education was introduced in 1989 in 13 selected 'demonstration' sites. It was a radical departure from the traditional scheme in many ways, principally:

* the education base was a department in an institution of higher education;
* students were supernumerary (i.e. not a component of the staff of clinical areas) and are allocated for educational purposes, not for staffing needs;
* students are paid a bursary, instead of the traditional training allowance,

* there is an 18 month common core foundation programme for all students, with a specialist 18 month course to prepare them for a specific part of the Register (Adult, Children's, Midwifery, Mental Health or Learning Disabilities Nursing);
* second level (Enrolled Nurse) training was to be abolished.

The loss of student labour was to be replaced mainly by Health Care Assistants who would train through the National Vocational Qualification scheme.

Project 2000-educated nurses, with a deeper theoretical knowledge base and the possession of a Diploma in Higher Education, were seen as a potential threat by many existing nurses trained on traditional courses. The credit accumulation concept and the modularisation of courses meant that Project 2000 diplomates had credits amounting to two-thirds of a Bachelor honours degree (240 points of 360 point required for graduation). This enabled a 'top-up' course leading to a post-registration degree to be achieved within two years of part time study. Traditionally trained nurses appreciated this and there was an increase in applications from them for places on modular post-registration degree courses each year from 1989. The first Project 2000 diplomates were accepted for top-up degrees at the RCN Institute in 1994.

The climate was conducive to the rapid growth in post-registration degrees in nursing. Demand accelerated from nurses eager to graduate. Government policy encouraged a rapid increase in the proportion of people entering higher education. The Polytechnic and Colleges Funding Council was particularly sympathetic towards part time students because they were cheaper than full time, women were especially encouraged into higher education, vocational courses and modularisation were also favoured - all factors that were positive towards top-up degrees in nursing. Although this did not concern the RCN Institute, which was always independent of the NHS, nationally, nurse education was transferring from the NHS to the higher education sector. The newly established nursing departments were anxious to extend their numbers of degree course students, and later, postgraduates.

Attempts have recently been made to differentiate and expand the knowledge bases of nursing with the intention of reducing its reliance upon medicine to underpin practice and to produce greater cohesion among nurses. Claims have been made that concepts of nursing and nurse education have undertaken a major 'paradigm shift' over the last ten years, resulting from the decision of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting to introduce major changes to the pre-registration courses from 1989 (UKCC 1986). The traditional model used for nursing and nurse education was the ***medical model.*** This was based upon physiopathological concepts of disease and illness and physical nursing intervention to restore function and to ameliorate the effects of dysfunction. A reductionist approach was dominant, whereby disease processes and dysfunction was in most cases traced to abnormalities at organ or cellular level. There was little or no attempt to put the disease or illness into the psychological, sociological or spiritual contexts and preventive medicine was scarcely paid lip service.

There is a slowly growing knowledge base in nursing that is being built up through empirical research into the efficacy of nursing practice. In addition to the knowledge base per se (*'what is' knowledge*), there is the utilisation of this knowledge for carrying out the core practical work (*'how to' knowledge*) and the acquisition of a range of skills. These skills usually encompass intellectual skills, such as problem solving, psychosocial and language skills, especially communication, and psychomotor skills, for example manipulatory and tactile procedures, as is the case in medicine and nursing.

The establishment of professional preparation courses within the higher education sector is crucial to the recognition of the status of the profession. It confirms the worth of the knowledge base in terms of its depth and complexity (Eraut 1994) and allows comparison of attainment with other known and accepted professions. The academic level of the awards has a bearing on the relative status, both at the point of entry to the profession, that is after a course of initial professional education (IPE), and subsequent progress up the professional hierarchy - through

successful completion of continuing professional education (CPE). The position of medicine and nursing in terms of their educational level stand in stark contrast.

Doctors have been obliged to have degrees following an Act of Parliament of 1858 but it was approximately a century later when the first experimental Bachelor courses were initiated that lead to State Registration for a tiny minority of nurses. These courses were developed in the 1950s and consisted of a degree in biological or social science together with most of the elements of the (then) General Nursing Council's State Registered Nurse course, arranged in a sandwich format over four and a half years. Over the next three decades several higher education institutions developed initial professional education for nurses at Bachelor level, many in academic subjects plus nursing but increasingly new IPE degrees in nursing were developed. In 1985 however, only two percent of IPE courses led to a Bachelor degree, the rest having virtually no academic respectability (RCN 1985).

Managerial Control Over Nursing

The management of the NHS has been problematical since its inception in 1948, it failed for over 40 years to establish effective management structures and an integrated corporate culture (Strong and Robinson 1992: 10). There is, as yet, no reason to suppose that the latest changes in its management will be found to be the last. An outline of the most significant changes in NHS management and the effects upon nursing is given to provide contextual background to illuminate attitudes of nurses to situations in their places of work revealed in this research.

Before the advent of the NHS, and since, nursing has remained subordinate to medicine and of relatively little interest or concern despite its huge size (Strong and Robinson 1990: 16). Nurses have been denied the acquisition of professional autonomy at the practitioner level throughout their history. Instead, nurses have had management systems imposed upon them by their employers, usually through the influence of national governments, and often with statutory enforcement. In hospitals up to the mid-1960s, although the Matron was the head of the nursing services with usually a Deputy Matron, and one or more Assistant Matrons and/or

Administrative Sisters above the level of Ward Sister, the way nursing management functioned had little to do with formalised management systems, as represented in an idealised bureaucracy, but much more to do with the personal style of the particular Matron. There was general dissatisfaction with the way nursing services were being managed, with complaints emanating from doctors, hospital administrators and politicians as well as from nurses themselves. This dissatisfaction was a prelude to the introduction of a bureaucratic management structure for nursing that was to last eighteen years, from 1966 to 1984.

The Ministry of Health, in 1965, convened the Committee on Senior Nursing Staff Structure under the Chairmanship of Brian Salmon, the Deputy House Governor of the Westminster Hospital, to advise on a way forward. The Salmon Committee found that the de facto power of Matrons varied considerably from hospital to hospital, job descriptions for nurses in management positions were the exception, their responsibilities and accountability were vague and poorly understood, there were numerous unsatisfactory practices arising from ignorance of management principles and practice through lack of training and structured experience and there was no identifiable career structure.

The Salmon Committee recommended a fairly rigid management hierarchy, with provision for four management levels above the ward Sister (the first line manager). These were, in ascending order, Nursing Officer and Senior Nursing Officer (middle managers), and Principal Nursing Officer and Chief Nursing Officer who were top managers. Detailed 'model job descriptions' with set duties and responsibilities were set out for each of these managers in an appendix to the report (Ministry of Health 1966). A training course at the appropriate level was recommended before appointment to a management post.

As a result of the Salmon recommendations, the only route to promotion was through the management ladder, or, after a one or two year full time course, to a career in nursing education. There was very little opportunity to progress as a clinician and, although the Nursing Officer (NO) was recommended to have a dual management - clinical role, most NOs were appointed to be solely managers,

or where they accepted the job as a dual one, the management tasks were so time-consuming that there was little, if any, time available for clinical involvement. This tendency further demeaned clinical values and skills. The larger organisation structures provided career, rather than professional (clinical) openings and these career openings were increasingly seized by men (Macdonald 1995: 142). The top nurses were absorbed into the sphere of influence controlled by the government and employing authorities, became their 'agents' and they perceived their own role as implementing the government's and their employer's priorities (White 1986: 60).

Following the introduction of proposals contained in Management Arrangements for the Reorganised National Health service (DHSS 1972), the Chief Nursing Officers at Regional, Area and District levels were given organisational equality with the Chief Officers in other NHS management functions, i.e. administration, finance, community medicine and, at district level, general practitioners and representatives of hospital consultants. A District Administrator wrote, "given that the Chief Nursing Officer at district level was responsible for managing 50 percent of the labour force and over one third of the budget, nursing had moved into a very powerful management position" (West 1992: 54). Others believed that nursing was incapable of exploiting the potential of the position it found itself in. "Nursing was not a profession but an unwieldy conglomeration of divers, and for the most part, relatively unskilled workers, in no fit state to suddenly assume huge professional, financial and managerial responsibilities" (Strong and Robinson 1992: 19).

The Region, Area and District Management Teams were established as 'teams of equals' and consensus decision-making was the modus operandi. This meant that each team member had a veto over the other team members. Up and down the country there were examples of ineffective team management and a sense of drift in policy formulation - or the lack of it. Personality clashes, a failure to compromise and tribalist intrigues between factions were not uncommon among management teams. A particular problem was seen to stem from the power of medical syndicalism, whereby doctors resisted control through the adoption of

fiercely individualist tactics within each specialty but within a concerted professional approach (Strong and Robinson 1992: 17-21).

In 1983, the government appointed Roy Griffiths, seconded from Sainsbury's, to look into management of the NHS. He recommended an end to consensus management and its replacement by general management, with a Chief Executive who had decision-making authority and was directly accountable to the management board. General management was the standard approach within the commercial sector and the government imposed it on the NHS through a statutory instrument (DHSS 1984). The effect of the Griffiths report on nursing was that nurses lost the right to be managed exclusively by their own profession and their automatic representation on District Management Teams (Klein 1995: 150). From then on the power of nurse management and the nursing voice went into decline.

General management principles were in vogue from 1984 until the early 1990s. Each Health Authority was a compartmentalised entity and tended to be introspective with little incentive to improve efficiency in the use of resources. Further change was signalled when the influence of right wing members of the Conservative Party increased and together with Margaret Thatcher herself, they advocated a reduction in bureaucracy, a loosening of the power of the professions in the public sector and the introduction of business values, as laid down in the NHS and Community Care Act (DHSS 1990).

The intention of the new right politicians was to improve efficiency by the imposition of a market economy by opening up the supply of services to competition. The effects were to flatten management structures, enable 'managers to manage', exact greater accountability and reward entrepreneurial success through 'performance related pay' incentives. In the NHS this was brought about by the creation of an 'internal market', introduced on 1St April 1991, in which general practitioners became budget holders (the purchasers), and hospitals and other service providers competed with each other, mainly on price.

The imposition of these changes caused a further economic tightening across the entire NHS structure. For nursing, especially in hospitals, it meant a loss of nurse management posts and a downward cascade effect, reducing the number of registered nurse posts overall and lowering the pay grades for many nurses. After the election of the 'New Labour' government in 1997 yet another policy change for the NHS was inevitable. In February 1999, the Secretary of State for Health, announced in parliament that the internal market would be abolished and the nurse grading structure would be simplified because it was unnecessarily complicated.

Each of the changes has had an effect on the way nurses viewed their work and the relationships with others with whom they work. Individual nurses have their own perspectives and a together they will hold a wide range of opinions, some will be relatively optimistic, others pessimistic about their futures. Those who have been practising over the past thirty years may well have changed their perceptions several times. The research will attempt to determine how those selected for interview perceive the present and the future in their chosen profession and whether these perceptions may have influenced their choice of degree course.

Current management pre-occupations with efficiency, value-for-money and economic competitiveness have imposed strains upon nurses in the workplace. Nurses feel that they have little control over patient throughput, healthcare policy and nursing staff skill mix. The consequences are nurses do not have the time to do what they believe is appropriate, cannot reach the standards they desire and that what they want to do is interfered with. The more senior they are the more autonomous nurses feel they ought to be. Too little autonomy may be a potent source of problems (Ackroyd 1993:40).

Patriarchal Dominance

Patriarchy has been defined as 'a societal-wide system of gender relations of male dominance and female subordination'. In effect, 'the ways in which male power is institutionalised within different sites in society' (Witz 1992: 11)

People have conventionally held strong gender stereotypes of masculinity and femininity: masculinity being associated with activity, independence, strength, confidence and rationality, while femininity is associated with passivity, dependence, weakness, uncertainty and emotionality. Qualities associated with masculinity are positively conceived but those associated with femininity take on a negative tone, or appear somehow residual - the absence of something rather than the positive presence of something else. This nineteenth century origin of gender dichotomy, Davies suggests, causes nursing to be devalued because it is seen as women's work (Davies, C 1996a).

The long established major professions of medicine, the legal profession and the clergy were traditionally exclusively male. Throughout most of their history they have been patriarchically focused in striving to maintain and strengthen their position. It has been claimed that these and most other professions form a 'generic' notion, a paradigm, of profession, consisting of class-privileged male actors at a particular point of history and in particular societies (Witz 1990: 675).

Vollmer and Mills (1966) observed that the most highly professionalised occupations have been, historically, almost the exclusive province of men. Maresh (1986) suggested that there were four barriers to professionalisation; feminisation, by which is meant socialisation into subservience; learned helplessness arising from powerlessness; hierarchical structures retaining power in male hands; and patriarchal dominance.

Female dominated professions have been consistently retarded in terms of their professional development and have found themselves in subordinate positions, either to other male dominated professions, as is nursing to medicine, or to management elites in bureaucracies, as has been the case in teaching and social work. Celia Davies argues that, while women may not be dominant, their contribution is nonetheless vital since without it work objectives would not be met. Further, that a central issue for the understanding of gender and profession in the contemporary era turns not so much on the exclusion of women but on a particular form of their *inclusion,* and on the way in which this inclusion is

masked in a discourse of gender that lies at the heart of professional practice itself (Davies 1996a).

Davies maintains that seeing gender as a social construction draws attention away from particular men and women towards constructed masculinities and femininities that are generalised and regularised. Binary thinking on gender (mistakenly) amounts to partial vision which confirms men as active subjects in the public sphere and can effectively undermine and silence women (Davies 1996a: 663). This approach, she believes, misses de facto relations between real men and women occupying interacting roles and the dynamics of role relationships, especially so when the researcher's study focuses on just one gender. Secondly, a focus on gender relations in which the qualities that women represent are constructed as 'devalued other' qualities (Davies 1996a: 664).

These qualities remain unacknowledged or denied, because researchers miss discovering the crucial benefits that women bring into relationships. Thirdly, there is an erroneous tendency to regard gender differences within organisations and institutions as fixed attributes, instead of active processes. Active processes are necessary to sustain gender relations to ensure effective functioning. Such relations can thus be challenged, dislodged and transformed in their daily functioning (Davies 1996a).

Davies found marked similarities in the modus operandi of relationships and decision making between doctor and nurse, and manager and secretary, with Weberian style bureaucracies of impersonalised office-holders, whereby the superordinate authoritively applies rules, maintains emotional distance, and makes impartial decisions while stifling individuality, compassion, flexibility and creativity. She maintains that the public face of professions is thus a masculine one, but, she argues, the 'essential' feminine role is eclipsed and largely unrecognised. Using examples of the authoritative businessman and the autonomous hospital consultant, Davies's contention is that *fleeting encounters,* with associates, in the case of the former, and patients, in the case of the latter, require *other relationships and activity* to interpret, communicate and translate

decisions into effective implementation. This activity is carried out by secretaries and nurses respectively and represents the essential other *half* of the conjoint entity needed to ensure the success of the enterprise, as long as the masculine role is unchanged (Davies 1996a: 670).

This essential feminine role is not acknowledged and women continue to struggle without such recognition when they seek change in the world of paid work and perhaps in the public world more generally.

> Women are asking for inclusion in a system of relations already predicated on a hidden form of their inclusion, a form, moreover, that does not work without this inclusion. Nowhere is this more painfully obvious in the world of professions than in the case of nursing. There are no words in conventional vocabularies or in sociological theorising to express the contradictions that nurses face, no easy ways for example, to bring a concern with caring onto the agenda without doing damage to conventional understandings of competence (Davies 1995: 672).

Feminist Perspectives

Feminism has been defined as, among other things, 'a world view that values women, and that confronts systematic injustices based on gender' (Chinn and Wheeler 1985). Basically, feminists assert that women have been oppressed by society's espousal of masculine values and attitudes from gaining access to institutions, education and employment and, thereby, have been prevented from achieving their full personal, economic, and social potential.

One of the main feminist contentions is that women are disadvantaged in the world of paid employment and especially with regard to the health service. In this context there is no doubt that in the past both men and women have harboured stereotypical views of what is typical men's work and what is typical women's work. The strong professions of medicine and the law being the epitome of the former, while caring occupations like nursing and social work typify the latter.

The economic position of men over women was taken by society as 'naturally' the more important and this stance is progressively changing towards gender equality, following gender anti-discrimination legislation. Research published in a report by

the Trade Union Congress, supported by evidence from the Equal Opportunities Commission, revealed that, on average, women earn 80% of the income of men when full time earnings are compared. Part time worker comparisons show that the gap widens to a 40% deficit for women (Daily Telegraph 25 May 2000). This exists 30 years after the introduction of the Equal Pay Act and much sex discrimination legislation. Men are much more likely to work full time, compared with a substantial number of women who work part time. The position within nursing is striking. Only 10% of the nursing workforce in the United Kingdom is male, yet one in six full time nurses is a man and only one in seventy-two is part time. The split among female nurses was full time 57%, part time 43% (Robinson 1992).

This has important implications for career development. Part time nurses receive much less continuing professional education and they have fewer opportunities for promotion to higher grades compared with their full time counterparts. There is a much higher proportion of men in nurse management and education roles. In the mid-eighties it was found that it took men 8.4 years to gain promotion from ward sister/charge nurse into line management, less than half the time taken by women of 17.9 years (Davies and Rosser 1986).

Nurses' Attitudes to Their Work

Studies into nurses' attitudes to their work have been conducted, the most notable in the UK, by Mackay (1989) and Ackroyd (1993). The principal thrust of Mackay's research was to ascertain the reasons for nurses leaving employment in a period of a worsening nursing shortage. Ackroyd's project was an investigation into morale amongst nurses in an acute unit.

Although dissatisfaction with pay and unsocial hours both featured in reasons nurses gave for feelings of frustration, these were at their strongest in those who had lost satisfaction from their actual nursing practice. Many of the 'satisfied' nurses commented that nursing is a vocation. The greatest satisfaction has been found to come from explicitly helping patients and their relatives and by 'doing a

good deed' and, intrinsically, through realising their own potential Mackay (1989: 134), and by taking responsibility for their decisions Ackroyd (1993: 39).

Dissatisfaction mainly stemmed from the frustration of not being able to deliver the standard of care that they believe is appropriate. This was found to lead to continuing stress and cynicism about nursing values Mackay 1989:141). Many nurses felt that they had little support from nurse managers and clinical colleagues. There were failures of communication in an over-critical 'bitchy' working atmosphere – a problem not new in nursing – the greatest single cause of complaint from unsolicited letters to the Briggs Committee (1972) Mackay (1989: 95).

Ackroyd found that even the most disaffected of the nurses interviewed were also capable of expressing considerable satisfaction with their job as well. He concluded that it is unjustifiable to assume that there is such a thing as a respondent's attitude – in the singular – towards work. While some nurses' attitudes appeared focused and enduring, others were either *volatile* (capable of changing rapidly to adopt a different value), or genuinely *ambivalent* (having two or more aspects permanently in tension). Professional values, which are likely to be ideals, do not exist in a vacuum: they are constantly measured against actual experience, which often falls somewhat lower, creating tensions. This makes means that compromises are necessary between the ideal and real work situations, although it is unlikely for nurses to respond to difficult work conditions with diminished work effort (Ackroyd 1993: 32-33).

Ackroyd proposed three possibilities in respect of the determination of attitudes to nursing and associated level of morale. First: resolution of tensions in favour of continued commitment to the profession and continued good practice. Tension between ideal and reality is resolved by the triumph of idealism. Sufficient correspondence between basic value commitment and actual experience can sustain *the traditional conception of nursing practice*, making it likely that nurses will continue in the profession 'come what may'.

Secondly, (the antithesis), negative feedback from actual work experience leads to the basic value commitments of nurses being progressively eroded. Tension between the ideal and reality is resolved by pragmatic recognition of the realities of service. Again producing a potentially stable outcome but where the *traditional professionalism is much reduced.*

Thirdly, there is a continued co-existence of satisfaction and dissatisfaction in the thinking of the individual. Ambivalence of attitude is present and volatility, (perhaps extreme), in expressed attitudes can be expected. Circumstances in the personal lives of individuals outside work are likely to be critical in formative career decisions. Pressures outside can readily be reinforced by stimuli generated in the workplace and cause an individual to quit (Ackroyd 1993: 42).

Professional Autonomy

Professional autonomy is the power to make one's own decisions within the recognised sphere of work without recourse to, or interference from, another. Professional autonomy is conferred through recognition of a professions unique knowledge and skill (Freidson 1994: 730), it can be expressed by a profession when it is allowed to constitute and control a market for its work (Larson 1977:56), it is a mechanism for the division of labour through credentialing (Freidson 1994: 160). Practitioner autonomy is central to the idea of a profession (Hoyle and John 1995: 77).

Autonomy in the widest since is generally regarded as being exercised by the medical profession since it has a virtual monopoly over medicine and health, even to the extent of deciding what constitutes medicine and health. As discussed earlier, doctors seek to control the agenda in all matters in their field. This inevitably means exercising control over other professions and occupations that also work in the fields, thereby imposing a restriction on *their* autonomy. Professional autonomy can be abused and, in the case of medicine, numerous doctors have ridden roughshod over the rights of patients. In the worst of recent cases, two consultant surgeons, in paediatric cardiology at Bristol, and in gynaecology in Kent, were found to have been grossly incompetent and

unprofessional, their fellow professionals were reluctant to take action to prevent recurrence and the General Medical Council took inadequate or tardy disciplinary measures against them.

Doctors control the medical/nursing boundary, effectively circumscribing the scope of nurses and limiting their autonomy, even though the distinction between curing and caring does not appear to be a sufficiently clear boundary to carry the weight of differentiating between the two professions (Walby and Greenwell 1994: 53). Medical restriction of the autonomy of nurses occurs both at the professional macroscopic level through their professional associations, sometimes with the backing of the state, and at the microscopic level through the actions of individuals in discrete clinical units.

Hoyle and John refer to professional autonomy being relative rather than absolute. It is always constrained; practitioners do not have licence, but have *a* licence to practice. They also draw attention to the contextual importance of autonomy (Hoyle and John 1995: 78). These points are certainly relevant to the relative autonomy of nurses.

Before the advent of the nursing process, with its focus upon individualised patient care and a named nurse responsible for caring for 'her' patients, nursing work was largely task-centred and prescribed by the ward sister. Each nurse would be allocated to perform the same task for all of the patients requiring this aspect of care in the ward. This also meant that each patient would have fragmented care carried out by several nurses. This routinised pattern of care was set at the foot of a management hierarchy that was heavily rule-bound, thereby discouraging autonomy. The nursing process required decision-making by each nurse and reduced dependence on superordinates. Paradoxically, it was also used to exact accountability for care outcomes and as part of a management audit process under the control of management.

The introduction of competency-based training in the 1970s, deemed to be necessary to improve the quality of care, especially in the nursing specialisms,

was a mixed blessing for the development of nursing. Certificates for competency are, in effect, yet another example of the rule-based approach to work that discourages autonomy. Fortunately this was replaced by an alternative ideological concept in the UKCCs Scope for Professional Practice (UKCC 1992) that shifts the onus of responsibility for care decisions onto each practitioner, thereby allowing for some relative autonomy to be exercised.

The structural organisation and power distribution of medicine and nursing has always been markedly different. Doctors have had an enduring approach that has been within their own control and has changed little over most of the twentieth century, whereas the structural organisation and power distribution of nurses has been largely outside of their control and has been the subject of several significant changes, introduced through force of legislation (DHSS 1972, DHSS 1984), or influenced by officially sanctioned reports (MoH 1966, DHSS 1986, DoH 1989).

The medical profession operates as a *collegiate* (Johnson 1972), whereby all doctors exercise power, in the form of autonomy in clinical decision-making. To the external observer the profession presents a strong image of internal unity. The political power of the medical profession is distributed to professional representatives who sit on official committees and through bureaucratic office-holders, usually at the top of the organisations concerned. Professional cohesion has been strong and the 'party line' has characteristically been supported through thick and thin. The power distribution to practitioners is equally strong. Every doctor is individually responsible for decisions about direct care of patients.

By contrast, nursing is considered to be a *mediative* profession (Johnson 1972) in which power is exercised through a mediator between the practitioners and the users of the service (the patients). Nurses are said to provide services to patients on behalf of the agency, the health service or doctors. However, individual nurses are responsible for defining the needs of their patients and the manner in which the needs are met (Macdonald 1995: 134).

The biggest problem for nursing and its claim to be a profession is the lack of practitioner autonomy and its reliance on a hierarchical structure. But it was a hierarchical structure that stemmed not so much from within nursing itself, as from many powerful forces – medicine, gender and the demands of an extremely labour intensive industry – which has created, shaped and controlled the nursing trade (Strong and Robinson 1992: 39). The structure has not remained static but has been subjected to several changes above the levels of Staff Nurse and Ward Sister. Changes to the management structures have been made for a number of reasons, at the behest of politicians in a quest to redistribute power among members of management 'teams' or to align them more closely to their espoused values. In most workplaces, since the management changes emanating from the NHS and Community Care Act 1990, the nursing hierarchy has ended at the Ward Sister level to produce a flatter structure but this has not in itself added to practitioner autonomy.

Professional Organisation and the Professional Project

Professional organisation has a vital role to play in the attainment and maintenance of professional status and power. Professional organisations are the result of a strategy to achieve a profession structure through two processes, the organisation of a market for services and the process of 'collective mobilisation' to attach status and social standing to their occupational roles (Larson 1977: 66). The organisation of the market entails recruitment, standardised education and credentials for admission and a licence to practice. Collective mobilisation is concerned with manipulation of the professional environment using notions of collegiality, loyalty, internal equality, democracy an ethical code and altruism – the modern professional ideology (Brante 1990:86).

The first step in pursuit of a professional project is the creation of a formal occupational group (Macdonald 1995: 195). (In this discussion the term professional group is more appropriate and will be used.)

Nursing has two distinct types of professional bodies, the legalised, or statutory, bodies – the United Kingdom Central Council and the four National Boards for

Nursing, Midwifery and Health Visiting, responsible for governance of the professions, and the professional associations that are primarily concerned with representing the profession as a whole in arenas appropriate to their fields and also to further the interests of minority groups and individuals that compose its membership.

The UKCC maintains the live register of qualified nurses who are currently licensed to practice, the administration of the disciplinary machinery to determine an individuals suitability to remain on the register and to readmit those who are deemed to have been rehabilitated and fit to return to practice. It sets the parameters for education at pre-registration and post-registration levels and the codes of professional practice. The UKCC has been active in bringing about important reforms in all the areas of its responsibility since it was set up in 1979 as part of the continuing professional project of nursing.

Its achievements have been, the change from the principle of 'registration for life' with no requirement for continuing professional education (CPE) to a mandatory re-registration every 3 years upon demonstrable of evidence of having undertaken a minimum amount of CPE, the introduction of the Project 2000 education scheme for registration, the change from a rule-bound competency certificate training approach to a more professionally autonomous approach with the onus placed on practitioners for deciding whether they are adequately equipped with knowledge and skills for aspects of care.

The National Boards operate within the frameworks stipulated by the UKCC and are mainly concerned with publishing curricular and approval of education schemes and encouraging related professional developments in their particular countries.

The main professional association for nurses within the UK is the Royal College of Nursing, with a membership in excess of 310,000. The College of Nursing was founded in 1916, three years before state registration for nurses was introduced. It has three functions. It is a traditional professional association for the furtherance

of the professional project through representing nurses in a wide variety of for a where professional issues are involved, it has a trade union function, having been certified trade union in 1977 as required by legislation. It is an independent trade union, (not affiliated to the Trade Union Congress), that operates a 'no strike' approach to industrial relations', representing the profession as a whole in salary and conditions of service deliberation with other official bodies, and represents individual members in labour relations and legal matters.

The third function of the RCN is in providing higher education through its education institute that was described earlier.

The RCN has been closely involved with furtherance of the professional project of nursing through the commissioning of work demonstrating the benefits of greater professional autonomy and in pioneering a number of developments in education and nursing research. Its role in this regard is to mobilise professional opinion and represent it in all matters that will enhance the status of the profession and to achieve greater autonomy for practitioners.

Summary of Issues Relevant to the Aims of this Research

The literature review has led to the identification of the following main issues that are likely to be relevant to this research and to assist in the interpretation of the findings.

- evidence and signs of professionalisation or deprofessionalisation
- inter-professional relationships with doctors
- evidence of engagement or commitment to the professional project of nursing
- evidence of personal involvement in enhancing or extending the nursing role
- level of satisfaction with the relative autonomy that can be exercised
- attitudes to work and indications about morale and the status/ esteem of nursing

Analysis and interpretation of data in relation to the above issues will attempt to identify differences between the hospital nurses on the Health Studies degree and those on the Nursing Studies degree to ascertain whether the two groups are likely to have chosen their different courses due to them experiencing different perceptions about the current position of nursing in its professionalisation project and their attitudes to their own careers.

Chapter Three

Conceptual Framework and Methodology

With references to relevant literature, this chapter explores the methodological concepts and principles that were utilised as a conceptual framework for the research. The research design is outlined and descriptions are given of how the quantitative and qualitative data were collected and managed.

The researcher was an experienced nurse educationalist with many years' experience of interacting with nurses occupying a wide range of nursing roles and had himself undertaken research using quantitative survey methods. More recently he had undertaken a qualitative research module on his doctoral programme, was interested in this approach but had no experience in conducting qualitative research. He had thought at some length about which methodologies might be used and had discussions with a number academics involved with the EdD programme at the University of Bristol. He was aware of a number of the factors and the arguments concerned with quantitative and qualitative methodologies that he had considered.

As described in the introductory chapter, students were making choices about which degree to take but it was not known what factors they took into account prior to making their choice. The central problem that the research set out to address was; **what** influenced nurses in making their degree choices and **why** did around one half of hospital nurses undertake the more generic Health Studies degree rather than the more focal Nursing Studies degree.

Consideration of Research Approaches

In any research study, when the objectives for the study have been determined, the researcher must consider what research paradigm or paradigms will be the most appropriate and productive in gathering data, interpreting them and answering the research questions. The history and tradition of quantitative research in the social sciences is much longer than qualitative research and has its basis in the natural

sciences. For several decades there has been a debate that has been recorded in the literature about the standpoints and the relative values of quantitative and qualitative research as the means of generating data for answering research questions in systematic social enquiry. Writers who have compared the two fundamental approaches have characteristically set down the different elements of each as pairs of opposites as the following example illustrating educational research demonstrates. Quantitative educational research is often characterised by hard, fixed explanatory data which are objective, value free, rigorous, atomistic, and universalistic. It embraces hypothesis testing, is deductive, empirical or behaviouristic and imposes positivistic scientific theory. Qualitative research, on the other hand, is presented as being virtually diametrically opposed; being characterised by a soft, flexible or fluid approach which is subjective, descriptive and exploratory, inductive, phenomenological, idiographic and holistic, thereby being interpretive and relativistic (Burgess 1985). Quantitative research is primarily concerned with cause and effect, whereas qualitative research is primarily about process and meaning (Bogdan and Biklen 1994: 156). This research had to elicit biographical and professional facts and inter-relationships but also, more critically, to tease out the thoughts, perceptions and interpretations that the individuals had that were not accessible to survey techniques.

Objectivity and Positivism

Until the 1950s, positivism was the dominant paradigm of quantitative research. Positivism embraces 'hard' scientific method modelled on the natural sciences and in particular on physics. Method is concerned with the testing of theories by experiment that will confirm or reject the veracity of causal relationships. This demands the strict control and manipulation of variables, clear and unambiguous observation of directly observable effects, and/or accurate measurement of changing conditions of materials (in physics and chemistry) and, or phenomena. Experiments must be capable of replication and results must be entirely consistent to be acceptable. Characteristically, laws were written and applied when such conditions were met. It is argued that scientific theories must be founded upon, or tested by

appeal to, descriptions that simply correspond to the state of the world, involving no theoretical assumptions and thus being beyond doubt. Great emphasis is essentially given to the procedures for standardisation of data collection, which is intended to facilitate the taking of measurements that are stable across observers (Hammersley and Atkinson 1995: 4).

Social scientists utilised the positivistic research paradigm from the late nineteenth century onwards, often together with qualitative methods, but the hard physics-based model was too unyielding to capture the diversity which naturally occurs in human activity. In reaction, social scientists in the nineteen fifties, developed a modified approach that was based upon principles of nineteenth century biological research that was coined 'naturalism' (Hammersley and Atkinson 1995: 6).

The fundamental principle of naturalism is that, as far as possible, the social world is studied in its 'natural state' undisturbed by the researcher. Supporters of naturalism claim that the approach can discover crucial aspects of human behaviour and identify empirical facts and thereby build up a theory of social behaviour. They contend that their methods largely dispose of the problems of subjectivity. However, many writers, including Kuhn (1970), Cohen and Manion (1994) and May (1997), argue that this is not the case and that the researcher's beliefs influence the research process the whole way through from the design to the conclusions.

Kuhn pointed out that the researcher's orientation and belief in existing theory can cause them to focus their efforts in particular directions that prevent them from becoming sufficiently objective. He demonstrated that even hard scientific research often does not systematically home-in on the truth by incremental advance progressively and by evolution, but that 'old' theory is overturned as a result of revolution, when theoretical suppositions forming the paradigm are challenged and replaced. Kuhn cited the successive ousting of Newtonian physics by relativity theory which was in turn ousted by quantum mechanics. This implies that the validity of scientific claims is always relative to the paradigm within which they are

judged; that they are never a simply a reflection of some independent domain of reality (Kuhn 1970).

Comparison of Quantitative and Qualitative Approaches

Based upon an analysis of the work of Burrell and Morgan (1979), Cohen and Manion (1994: 5) explored the two competing approaches to discovering the social world, the traditional **realist** view that the social sciences are essentially the same as the natural sciences and are therefore concerned with discovering natural and universal laws regulating and determining individual and social behaviour, and the radical **nominalist** view, that emphasises how people differ from inanimate natural phenomena and, indeed, from each other.

Four sets of assumptions, in the form of dichotomies, were considered. First, the **ontological** kind: is social reality *external* to individuals, imposing itself on their consciousness from without, or is it the *product of individual consciousness?* The second, of the **epistemological** kind, concerns the basis of knowledge, its nature and forms and how it can be acquired and communicated to other human beings. Is it possible to identify knowledge as being hard, real and capable of being transmitted in tangible form, or, is knowledge of a softer, more subjective, spiritual or even transcendental kind, based on experience and insight of a *unique and essentially personal nature?* That is, whether knowledge is something which can be acquired on the one hand, or is it something which has to be personally experienced on the other. Cohen and Manion (1994: 6), contend that to subscribe to the views that social reality is external to the individual and that knowledge is hard, is to be positivist. If one subscribes to the alternatives, then one is anti-positivist.

The third set of assumptions concern **human nature**, and in particular, the relationship being human beings and their environment. They assert that two images emerge of human beings and their environment. One is an image of human beings responding in a *deterministic* way, the other is as *voluntary initiators of their own actions.*

The fourth set of assumptions concerns the **methodological** approach to investigation of the social world. If one is positivist and a believer in the deterministic foundation of human beings responding to their environment, then the quantitative *nomothetic* methods will be appropriate for the research. Whereas, if one favours the alternative view of social reality, which stresses the importance of subjective experience of individuals in the creation of their social world, then the appropriate research approach will be qualitative, or *idiographic* (Cohen and Manion 1994: 7).

In summary, quantitative and qualitative research methods each have their strengths and their limitations. In most research studies there is not simply one best approach. Paradigms are not closed systems of thought hermetically sealed off from one another (May 1997: 35). They are not mutually exclusive and both major paradigms can be used within research studies in complementary ways. Each, unavoidably, combines objective and subjective elements in different measure. Any particular application of one or the other can be considered to occupy a position along an objective < > subjective continuum, or, changing the concepts and terminology, the following continua; quantitative < > qualitative; nomothetic < > idiographic; realist < > nominalist.

Subjectivity and Social Reality

Researchers who are opposed to the use of naturalism argue that researchers cannot be truly objective since they unavoidably view the social world from their own perspective, seeing people and events as *constructions* that are coloured by their own values, prejudices, philosophical and political presuppositions and expectations, irrespective of conscious efforts to be objective. Futhermore, the people who are the 'objects' of their study also do themselves construct their own realities and each has a unique interpretation of the social world, imbued by social meanings that have been influenced by their own values, beliefs, motives, intentions and rules before social researchers arrive on the scene (May 1997: 35). Data that they supply are, therefore, products of subjective processing of their perceptions of previous events, as well as the present interaction.

Although some social data can, and indeed are, best elicited by using an objective quantitative approach, people do not exist as if in a vacuum, conforming to rules and open to direct observation. The intricacies of social life require that researchers concentrate upon *how people behave* to produce social interactions. Social researchers need to discover people's selection and interpretation of events and actions and how they interact with each other and the researcher - a process known as inter-subjectivity (May 1997: 10-14).

All individuals make sense of their lives and orientate themselves within society through constructing relationships with others and accepting knowledge acquired through their own experience and from the media. Knowledge, values, attitudes and behaviour do not exist in a vacuum but in social contexts where the world of everyday life is the scene and also the object of our actions and interactions (Holzner 1968: 2). People have a need to interpret all aspects of their world in order to make sense of it, to conduct themselves in appropriate ways, and to achieve goals that they may set in their personal and social lives. Knowing that, what, why and how to, in social contexts that a person is part of, is necessary for optimal functioning. The more complex one's occupation and relationships, the greater the need for interpretation of the social realities.

The knowledge of truth or reality is never absolute but is discerned through the *mapping* of experiential reality by the observer; it is not the grasping of reality itself (Holzner 1968: 20). The point being made is that reality is in the mind of the perceiver and is our *representation* of reality in a similar way that a cartographer constructs a map or a painter sees, interprets and depicts an image that s/he is confronted with. Every individual is concerned with the social construction of cultural meanings, maps and models that define and determine what we take for granted as reality (Holzner and Marx 1979). It is these constructions, perspectives and orientations that guide nurses in decision making in their workplaces and selection of their continuing professional education and development. Crucial influences on individual perception and behaviour arise from social relationships

with significant others and the freedom for decision making allowed within these relationships.

All individuals are actors in a number of social environments. Their interactions with others take place within structured relationships where each actor can (usually) recognise the relative position of herself/himself and others. These positions are known as roles and each role is invested with properties such as power, status and usually a degree of freedom, if not actual autonomy. Role-holders have commitments, obligations and expectations. Although a role is a distinct entity it cannot exist alone but is itself linked to at least one other role - interdependability being a function of role relationships.

Role-holders, to varying extents, have a certain scope in which to exercise their will to perform their roles. That is, roles enjoy a sense of separateness, a degree of *autonomy* (Katz 1976: 62-63). Limits to autonomy become understood and acted out through the experience of repeated interactions. Norms and expectations of behaviour in social settings evolve and are experienced and acknowledged in terms of promise of rewards or freedom from sanctions for compliance and the possible imposition of sanctions or the lack of rewards for transgressions. These constraints on role behaviour may be imposed by legal or bureaucratic edicts but most are socially determined by other role holders within a role-set.

In healthcare settings there are numerous different categories of role-holders; patients, doctors, nurses, physiotherapists and many others. Each of these different categories of role-holder, as well as levels of seniority within each category, will have different relationships with each of the others - different degrees of autonomy and different social behaviours one with another. Within each category will be found individuals who conform to a relatively narrow range of recognised, conventional 'safe' behaviours, while other individuals, usually far fewer in number, will engage in 'marginal' behaviours that are perhaps potentially risky or even deviant. It is this latter type of individual who is likely to pioneer the challenging of conventional role behaviours and role boundaries between

professions such as medicine and nursing, perhaps using strategies of occupational closure (Parkin 1979, Witz 1990).

These issues of autonomy and the challenging of existing conventional role boundaries are likely to arise from the extension of knowledge by three main ways; by the usurping of knowledge by the 'intruder' from the existing guardian, by the new incorporation of knowledge from other disciplines or by the generation of new knowledge by the expanding profession through research. All of these ways of extending knowledge, and thereby professional practice, have been occurring in the case of nursing vis à vis medicine over many decades. It may be that relocation of nurse education within universities will enhance the confidence of nurses and enable them to effectively challenge existing limits to their autonomy.

When people choose particular courses of action when no apparent compulsion is being exerted upon them, it is likely that they will be largely influenced by their social construction of reality. Since registered nurses do not need to gain a degree to be able to practise as nurses, those who do read for a degree have exercised their freedom to do so. It is therefore, already evident from the problem that has been identified, that there is a choice to be made about which degree to choose. Each individual experiences and re-experiences their own reality and will perceive their changing repertoires of knowledge and skills in respect of their practice, in terms of their standard of competence, their relative deficiencies and their need for additional learning and mastery. Their perceptions are likely to be shaped by the professional appointments that they hold and by the opinions of others, particularly those in senior positions in their organisations and peers who they most respect as innovators or who enjoy high status as good professional role models (Rodgers 1962).

Conceptual Framework for This Research

The researcher became interested in this problem of degree course selection because of his occupation as a manager of the Institute. The selection of this single research site determines the research as a 'case study' with, essentially, a number of unique circumstances that will influence the perceptions and decisions of the subjects of the research and, of course, of the researcher himself. Readers must bear this in mind, as findings are likely to have been dependent upon a number of factors inherent to this research that may not be generalisable to other institutions. To a certain extent, similar problems exist in all cases where research is confined to a single site or a few sites with strong similarities.

The overall aim for the research was the discovery of fundamental social 'facts' that would provide a broadbrush picture about each of the degree course groups and enable decisions to be made about categorisation of individuals within each group by key characteristics. An important stage after the collection of quantitative data was looking for 'patterns' that suggested meaning or a potentially fruitful area to follow up. This in turn would lead to the selection of a sample of individuals for interview who, between them, would encompass an acceptable range of the key characteristics. It would also pave the way for the identification of areas that appeared to be crucial for progressive focusing down in order to discern the critical points of difference between the groups.

The researcher subscribes to the view that the social world is composed of a complex interplay of social events which occur in a range of different social contexts, the home, occupational settings, leisure activities, religious ceremonies, etc. Each individual interprets their social world and acts according to the meanings that they ascribe to these events, based upon their intentions, motives, beliefs, rules and values.

Each individual's construction of their reality will have both philosophical and psychological dimensions that need to be discovered through an exploratory dialogue that circumvents and reaches beyond the objective factual dimension. The

researcher will need to appreciate the way that the subjects think and feel about aspects of their professional lives that are crucial to them and to tease out their opinions of professional matters.

The researcher's subjectivity influences the framing of the research questions, the formulation of each of the questions used to collect data, the interview itself, the collection, extraction, analysis and interpretation of data and the drawing up of the conclusions of the research in answer to the research questions. Subjective dimensions of the social researcher, once acknowledged and understood, may be regarded as inevitable and to be used to advantage. The fundamental assumption is that social researchers are part of the social world that they study. By being reflexive, the researcher accepts that his personal orientation has been shaped by his values, interests, past experiences, beliefs, hunches and, thereby, constitute his biases (Hammersley and Atkinson 1995: 16).

A constant issue and challenge for the social researcher is to use reflexivity to maintain awareness of the possible influences of all his subjective dimensions and to focus upon identifying and recording data that represent the reality of the situation through asking particular questions, interpreting the replies, writing fieldnotes, transcription of audiotaped recordings and the writing of research reports. In this way the researcher becomes the research instrument (Hammersley and Atkinson 1995: 18-19).

The researcher believed that students' decisions about which degree to pursue would be strongly influenced by their individual conceptions of professionalism in relation to their experiences and perceptions of their own future career progressions and the future professonalisation of nursing. He conjectured that differences would be found between followers of the Health Studies and the Nursing Studies degrees in the context of the models of professionalism outlined in chapter two. He intended to analyse and interpret the data to ascertain the nature of the differences in orientation to the models.

He postulated that those who chose the more traditional Nursing Studies course would be more likely to be more humanistic and more closely aligned to the *functionalist*, altruistic model of professionalism, with an intrinsic focus on traditional caring values. Those who chose the newer and broader Health Studies degree course, he believed, would be more likely to think and act more openly and widely, with a greater awareness of inter-professional rivalry and to subscribe more closely, either to the *power* model or to the contingent *process* model of professionalism. Such models in the nurses' minds are more likely to be implicit in guiding their behaviour rather than explicit and intact.

There was no existing published theory on factors that led to nurses choosing a degree course or whether nurses espoused different models of professionalism and what caused them to do so. Although the researcher had ideas and beliefs about it, outlined above, he did not formulate tight hypotheses, as such, that could be tested by findings, instead he favoured developing theory through systematic data collection and subsequent reflexive distillation and interpretation

It was decided that the first stage of the research would be quantitative and that it would be necessary to elicit biographical and professional facts about the total population that was selected for the study. Research Aim 1 and the related questions (reproduced below) would be addressed by analysis and categorisation of quantitative data obtained from the Institute's Computerised Management Information System and a survey questionnaire.

Aim 1. *To ascertain the professional profiles of those choosing the Health Studies degree and those choosing the Nursing Studies degree, in particular of nurses working in hospitals.*

Research questions arising:

1.1 What are the characteristics of the people who apply for these different degrees, in terms of present employment, age, educational and professional qualifications and professional history?

1.2 Are there differences in the profiles of hospital and community nurses and between hospital-based nurses on the Health Studies and Nursing Studies degrees?

The collection, analysis and interpretation of these quantitative data would provide an appreciation of the range of characteristics that were possessed by the subjects on each of the two degree courses. This would enable any basic biographical differences that there might be between the cohorts to be distinguished. Identified differences could lead to judgements being made about the relevance or otherwise of their choices of degree course.

It will be necessary to be able to assign each subject to a number of categories to compare aggregated data. Manipulation of aggregated data will put the researcher in a position to understand relationships between any two categories and to directly address some of the research aims and their subordinate research questions. This could lead to findings which might be directly relevant or could indicate areas that would require further exploration during the second, qualitative stage of the research. Two examples of comparison of categories being; age distributions of the subjects on the two degrees and time spans since registration.

Within a given broad occupational grouping, such as nurses, there are inevitably a number of sub-groups that may be identified, determined by the type of nursing practised, professional seniority, work location, etcetera. It is likely that some differences in interpretation and behaviour, resulting in the type of course chosen, will be influenced by membership of particular sub-groups, through a relatively common interpretation of what is most appropriate for the sub-group in question. However, individual differences in belief and interpretation of their profession and

the reasons for choosing to undertake their courses could still span the entire spectrum among the members of any one of the social sub-groups.

A detailed qualitative approach was considered essential because it was anticipated that decisions about course choice would not be wholly consistent with quantitative data. Instead, understanding would be much more likely depend on their (subjective) concepts and interpretations of their present and potential future professional social worlds that could be revealed though the collection and interpretation of qualitative data.

Although opinions about some fundamental social matters can be obtained from subjects by quantitative means, the researcher believed that it would be necessary to obtain more subtle and also more sophisticated opinions than were possible to elicit through the use of a survey instrument such as a postal questionnaire. Subjects will need to be asked questions such as, 'What is it like to be.....?' and, 'Why did you decide.....?' The key aspects of qualitative research being process, context and meaning rather than bare facts.

Both elements of the research were clearly essential, but the researcher considered the qualitative element of the research to be the more important of the two for several reasons. He believed that it was desirable for respondents to give their undivided attention to carefully thinking through the reasons and their personal contexts that led to their degree course decisions. He wanted to explore with them their opinions and feelings about a range of personal and professional issues that may have had a bearing upon their decisions. He also thought it was more likely to obtain more honest and reliable answers to a number of issues through interpersonal interactions occurring with closer rapport than was likely in answer to a printed questionnaire. This was subsequently borne out when analysis of the questionnaire data revealed few patterns to illuminate differences in students' decision-making, whereas important differences were elicited though the interviews, particularly differences in perceptions and attitudes.

During the interview stage of the research it was considered likely that respondents would reveal a range of differences in perception and outlook on professionally relevant issues; for example, in the extent and clarity of vision about likely developments of the profession of nursing, the possible future nature of the organisation of health services and society's changing attitudes to health and illness and the increasing emphasis being given to concepts of health, to health education and health promotion. Any or all of these personal perceptions may illuminate the decisions they made about whether or not to undertake a degree and, if so, which degree to take. The research questions arising from Research Aim 2 were used for this exploration.

Aim 2: *To determine the factors that influenced students in choosing their degree course.*

Research questions arising:

2.1: How much care did students take in choosing their degree course?

2.2 What reasons did they give for their degree course choice?

2.3: How valuable did students find their degree course to be in terms of their current and intended professional roles?

If nurses who chose the Health Studies degree had different perceptions about the current and future positions of nursing, compared to nurses who chose the Nursing Studies degree, then these differences in opinions, attitudes and behaviour about various professional issues may have been influential in them making their choice of course. If so, they should be discernible from their answers to questions on some important professional nursing issues that have been identified and set down as Research Aim 3 and related research questions.

Aim 3*. To determine whether there are differences in module patterns, values, opinions, attitudes and behaviour between hospital nurses on the Health Studies and the Nursing Studies degrees that may be related to their choice of degree.*

Research questions arising:

3.1 Are there differences in the patterns of module types in the make up of the two degrees?

3.2 Do graduates/students have different opinions and attitudes about nursing theory and models?

3.3 Are there differences in the perceptions that graduates/students have about professionalism and professional issues?

The Quantitative Stage of the Research

The quantitative stage of the research commenced with the extraction and analysis of personal biographical data from the institution's Computerised Management Information System (CMIS). This established the size and composition of the population by year of entry and exit to the programmes, age, gender and ethnic origins. The requirements of the Data Protection Act were fully respected regarding obtaining the permission of students and graduates in the use of data for this research.

It was known that the CMIS did not hold sufficient quantitative data that would be necessary for the research. It even fell short of the range of quantitative data that would be necessary to separate the subjects into robust categories that could be used for the qualitative stage. It did not, for example, hold information about the work roles or workplaces of registered students and graduates, so there was no way of knowing the proportions of community and hospital-based nurses on the two degrees. However, because community nurses are employed in considerably smaller numbers than hospital-based nurses, it was suspected that the popularity of the Health Studies degree was partly due to hospital nurses opting for this course rather than the Nursing Studies course which was specifically designed for them. (Data collected later revealed 52% of Health Studies participants to be hospital-based)

Typically, surveys gather data at a particular point in time with the intention of describing the nature of existing conditions, or identifying standards against which existing conditions can be compared, or determining the relationships that exist

between specific events (Cohen and Manion 1994: 84). One of the most convenient and efficient ways of gathering data through a survey is by means of a postal questionnaire. In this research, it was necessary to obtain responses to the questionnaire that would be likely to identify biographical and professional differences between the two degree course followers.

A survey instrument in the form of a postal questionnaire was designed, then scrutinised by experienced survey researchers at the RCN Institute, and despatched to the chosen population. Data on biographical and professional aspects were extracted, analysed and coded in order to assign each individual into the relevant categories for interpretation and for selection of the sample for the qualitative stage. The quantitative data that were extracted, analysed and used for selection of the qualitative element are detailed and discussed in chapter 4.

Survey by Postal Questionnaire: Design

According to Cohen and Manion (1994: 85), three pre-requisites should receive attention in the design of a survey: the exact purpose of the enquiry; the population on which it is to focus; and the resources that are available.

The purposes of the survey were: to augment the personal biographical and professional data held on the CMIS in order to provide a personal portrait of each subject; to enable personal data to be aggregated in categories for selection for the qualitative element of the research; and, to enable the researcher to gain some initial impressions of the possible reasons for degree choice and perceptions of the usefulness of the degree to the subjects' professional practice.

The total population was chosen to be the 761 subjects, (Health Studies 485, nursing Studies 276), who graduated from their courses in 1995 and 1996 and students who were registered at the start of the 1996/97 academic year. The rationale for the selection of this population is explained later. Everyone in this population was included in the quantitative stage of the research, comprising capture of the CMIS data and the mailing of the postal questionnaire. The sample for the qualitative stage

was selected following categorisation of respondents to the postal questionnaire and is also detailed later.

The resources available consisted of the 'part time' researcher, the CMIS database, assistance from the staff of the institution's registry, who interrogated the database and produced hard copy printouts, and who also undertook the printing and mailing of the postal questionnaire. The institution gave its support to the research being undertaken and it bore the cost of some of the work including the cost of the postal questionnaire survey. The researcher's own 486 Intel-equipped personal computer and relevant software, namely Pinpoint, Excel and Word, was used to process the work.

The difficulties of formulating an 'ideal' questionnaire for self-completion are well known and there is extensive literature on the subject. The researcher had previous experience of designing questionnaires for small scale surveys on a number of occasions and, as had been the case before, he used Selltiz et al's (1976) guidance 'checklist' in order to minimise the occurrence of problems. A copy of the postal questionnaire that was formulated for the research is included as Appendix A.

In the formulation of the questionnaire the following points were addressed. The respondents could be expected to have the knowledge, information and experience to provide the answers to all of the questions asked. The questions were concrete and specific to the respondents' personal and professional lives. An effort was made to avoid ambiguity. No question contained negative implications, irrespective of the range of possible responses. Questions were written with the intention of excluding bias and avoiding leading the respondent towards a particular answer.

The questions were arranged in sections and each section was numbered and named and confined to questions that related directly to the section title. A variety of different question types were used, including some 'closed' questions requiring a yes/no answer, most were 'open' questions, several of these were 'multiple choice' and some needed a judgemental narrative response.

The questionnaire included a brief explanation of the research and the reason for it and the usual assurance about guaranteeing the anonymity of the subjects' responses. This was given at the head of the questionnaire over the printed name of the researcher and title of Senior Research Fellow. There were four sections, containing between them, 22 questions that were to be used for the research itself. A number of experienced researchers in education and in nursing scrutinised the questionnaire before it was used and some minor revisions were made to a few questions. Because of this scrutiny and the fact that the whole of the population was to be surveyed, no pilot study was run.

After the responses were received from the first mailing it was found that no changes to the questions were needed. However, a number of these respondents indicated that they did not wish to be approached for an interview for the qualitative stage of the research. Accordingly, to assist in making decisions about who to select for interview, an additional 'courtesy' question was added at the end of the second batch of questionnaires. The wording was; 'If required, I agree to be contacted by the researcher for an interview - Yes/No'.

(The format, the section titles and the categorisation plan for segregation and analysis of the data from the questionnaire are contained in Appendix B)

The Population and the Sample

The decision to undertake this research was made in 1995 and at this time consideration was given to the size and composition of the population for the research. Between 1992 and 1995 the Health Studies degree was becoming increasingly more popular than the Nursing Studies degree, year by year. In the light of this it was decided to include those who started in at least three different years. However, because around 90% of students were practising professionals who were undertaking their courses on a part time basis, and many progressed to a degree course after gaining certificates and diplomas, coupled with the fact that a significant number of students had breaks in study, it was concluded that it would be more relevant to include three different 'cohorts', based not on start dates but on the

years of graduation. The subjects for the research were selected from among graduates of 1995 and 1996 and students registered in the academic year 1996/97 on the Health Studies and Nursing Studies degrees. The total numbers in the population were: Health Studies 485 subjects, Nursing Studies 276 subjects.

Questionnaires were sent in November 1996 by the Institute registry to all subjects in each of the cohorts, together with a reply-paid envelope addressed to the registry. The flow of returned questionnaires had almost dried up by mid February 1997. The return rate was somewhat disappointing, varying between 13% and 23% between the six cohorts with an overall return rate of 19%. This low response rate was almost identical to one received by a much larger national nursing education research study that the researcher was aware of, through being on the Steering Group. The questionnaires for this research were also sent out by the administration department of the organisation concerned.

It was decided to re-send the questionnaire to all non-respondents to the first mailing and this time to include a personalised letter to each of the subjects, signed by the researcher, together with a stuck-on postage stamp on the envelope which was addressed to the researcher's home address. It was thought that this more personal approach would be likely to increase the response rate. This mailing was sent out in late June 1997 and by mid September of that year the response rate had doubled.

RESPONSE RATES TO QUESTIONNAIRE

		Health Studies			Nursing Studies		
Cohorts		**Totals**	**Ret'd**	**% Ret'd**	**Totals**	**Ret'd**	**% Ret'd**
Graduates	1995	124	37		72	30	
	1996	180	76		68	27	
Students	1996	181	74		136	59	
		485	187	39%	276	116	42%

Table 3.1

. It was something of a relief to the researcher that the response rate was above the sort of levels which the standard texts regard as satisfactory for this type of study and that there was only a three percent difference between the two degree

populations, (39% Health Studies and 42% Nursing Studies). The final response rates are shown in table 3.1.

Around 60% of the population to whom questionnaires were sent did not respond. Scrutiny of data from the CMIS on age, gender, ethnic origin and starting year of the respondents and non-respondents did not reveal any major differences between the two groups.

The sample for the qualitative stage was selected from among the respondents to the postal questionnaire, 187 (39%) respondents from the Health Studies degree and 116 (42%) from the Nursing Studies degree. The response rate was considered to be satisfactory and sufficient for the purpose of providing descriptive snapshots of the two degree populations and the categorisation of the respondees to enable a *purposive sample to be selected for the qualitative stage.*

Due to the constraints of time availability for carrying out the interviews and the necessity of containing costs, the researcher decided to select a small but feasible sample that would include representation of all the essential categories that were identified through analysis of the quantitative data, (reference chapter 4). This type of sampling is known as *purposive non-probability* sampling. Despite the disadvantages that arise from its non-representativeness, it is far less complicated to set up, is considerably less expensive and time-consuming and can prove perfectly adequate where there is no intention to generalise the findings beyond the sample in question. (Cohen and Manion 1994: 88). However, although generalisations to larger populations are not made the findings may have a sensitizing function in relation to a number of current issues in nurse education.

This 'purposive' function relates to the fact that the researcher picks the sample on the basis of their judgement of the typicality of those chosen to aspects that are pertinent to the research, thereby ensuring that the sample is satisfactory to their specific needs (Cohen and Manion 1994: 89). The selection was made to include a

spread across age groups, course start dates, course finish dates, occupational titles, pay grades and gender.

The researcher acknowledged that in the necessarily limited number of respondents who could be selected for the qualitative stage, it would be unlikely that the sample would encompass the complete range of different personal and professional positions and interpretations that existed across the whole population of the two degrees. Therefore, he attempted to select the sample for interview that would encompass all the crucial categories that were found through the analysis of data from the respondents to the postal questionnaire who had also indicated that they were willing to be interviewed.

The interviewees lived and worked throughout London and the home counties with the exception of one who was from East Anglia. The researcher did not consider geographical locations as such when selecting the subjects for interview but he was pleased to see that when the selection had been made the geographical spread of interviewees reflected well the geographical spread of the institution's students as a whole. The quantitative data are displayed and analysed in chapter four.

The Qualitative Stage of the Research

The Interviews and Interpersonal Dynamics

The research interview has been described as a 'two-person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused by him on content specified by the research objectives of systematic description, prediction, or explanation' (Cannell and Kahn 1968, quoted by Cohen and Manion 1994 p271). In-depth interviewing probes beneath the surface, soliciting detail and providing a holistic understanding of the interviewee's point of view, allowing the researcher to enter the other person's perspective (Patton 1987:108-109).

Writers on in-depth interviewing generally recommend the use of audiotape recorders. The main disadvantage of their use, obtrusiveness to some interviewees,

is outweighed by the following advantages. It frees the interviewer from the need to write extensive notes of the interview content, (which can also be obtrusive), enabling greater concentration on following and interpreting the conversation and for recording non-verbal observations about the gestures and demeanour of the interviewee. Data capture is also more comprehensive and, after transcription, allows more thorough analysis and categorisation (May 1997: 124-125).

Both the interviewer (me) and the interviewees wore high performance personal clip-on microphones to reduce obtrusiveness and optimise the quality of the recordings. The tape recorder had automatic volume and balance controls to avoid the need for manual attention during the recordings. There was no doubt that the use of this good quality automatic equipment enabled the subjects largely to ignore the fact that the dialogue was being recorded. Confidence that the recordings were being satisfactorily made without the need for close monitoring and intervention enabled me to be more relaxed and attentive to what the subjects were saying than has been my experience with previous audiotaped interactions. Although there were inevitable differences across the fifteen interviews in terms of the intensity, comprehensiveness and warmth of rapport of the dialogue, the overall results were very pleasing and they turned out to be comparatively trouble-free, although very time-consuming to transcribe. All subjects agreed to the interviews being audiotaped for later transcription into hard copy.

An Interview Guidance Framework based on a schedule of twenty-four 'model' questions had been prepared in advance to ensure that no area considered to be of potential importance was omitted (refer to Appendix C). This also served as the coding frame for the responses. The interviews embraced two of the interview types described by May (1997), namely the semi-structured and the unstructured or focused. For the majority of the topics, the semi-structured technique was used in which the interviewer used 'probes' and 'invitations' (May 1997:111) to encourage the interviewees to clarify and expand their responses. For a few topics the unstructured technique was used. The use of the different techniques will be

apparent in chapter five which deals with the qualitative analysis and categorisation of data from the qualitative stage of the research.

The interviews took place during 1997 and 1998 and were conducted in quiet settings conducive to a relatively relaxed discussion. Five were in the subjects' homes, five in offices at their places of work and five in the education institution where the degree courses were being run.

The interviews were informal and relaxed in order to encourage interviewees to follow their own thoughts and to project their own ideas, rather than directed along particular pathways and into areas by the interviewer. The interviewer always tried to establish and maintain a congenial ambience and to encourage, as much as possible, a spontaneous and free flowing conversation. Consequently, the duration of the interviews varied from thirty-eight to seventy-one minutes. The duration of the interviews was determined largely by the personality of the interviewees, although two were almost certainly influenced because the interviewees were 'tight on time' available for the interview due to extraneous factors. The more expansive interviewees did not necessarily produce analytically richer material than those who were briefer.

Through his efforts to enter into the world of each of the subjects, the researcher set out to understand and categorise students' interpretations of their world and their perceptions, motivations and behaviours. The intention was to gain knowledge but not to pass judgements on the settings or on the subjects (Bogdan and Biklen 1992). The researcher encouraged the subjects to describe as fully as possible in their own words and sequence their feelings, ideas and intentions concerning their perceptions of the future development of nursing, their own professional development and their courses in relation to their own careers. Except for a small minority they provided free-flowing descriptions which appeared to reflect their knowledge and beliefs - their individual social constructions of their realities.

Efforts were made by the interviewer to gather data that were as uninfluenced as possible by him. He does, however, realise that the collection and interpretation of all data to some extent involve theoretical suppositions and are therefore cannot be entirely free of bias. (Hammersley and Atkinson 1995). His own subjective feelings about the topics under discussion, his interpretation and judgement about each interviewee and his own experiences in similar or dissimilar professional situations can affect his analysis and interpretation to some extent and could be said to be potentially biased.

The researcher was aware of his need to avoid over-inference of meaning from the responses of the interviewees, especially when interpreting data relating to issues of professionalism and professionalisation – concepts about which they may be unfamiliar and would not naturally use.

Fieldnotes were made of the circumstances of the interviews, the ambience of the venues, features of the interviewees including their demeanour, personality, general appearance, whether they were on or off duty, their apparent state of relaxation. The researcher acknowledges that, like everyone else, his values, beliefs, opinions and prejudices can colour the way he asked questions, responded to comments made by the interviewee during the interview, selected dialogue from the tape during transcription and interpreted the meaning of what was said. During reflection at various times during the entire process, he consciously tried to minimise the risk of his own distortion of events.

There were readily identifiable differences in the nature of the dialogues. Some interviewees seemed to be relaxed and confident right from the outset, others were clearly showing some tension for a few minutes until a rapport became established. The researcher was deliberately light-hearted and made positive efforts to enable the interviewees to relax before the interview proper started. This mainly took the form of the researcher encouraging the interviewee to talk about something topical, either professionally or more generally, and getting her/him to establish herself/himself on 'home-ground' through talking about themselves or their work beforehand. The

actual wording of the questions that were put to the interviewees varied according to their preceding responses and the dynamics of the interview. Occasionally the ordering of the questions was changed when it seemed appropriate to maintain continuity of the dialogue or to follow the drift of the interviewee's discourse.

The researcher was aware that there is always a social context that is perceived by each of the participants in any interaction. Each person will place themselves and the other/s in relative positions of status, authority, power, social class and will also be aware of the relative ages, sex and demeanour. The social perceptions of the self and of the other person can, to various extents, affect the dynamics and the quality of the dialogue. The interviewer was a white male who was formerly in a position of authority in the institution concerned. It is probable that the majority of the respondents were aware of his former position as Principal of the institution because they were students at that time. Others may have been unaware of this and it is likely that many of those who were current students were not aware.

All but four of the fifteen interviewees were women and this may have affected their responses in some way. However, all of them, as nurses, many in fairly senior positions, have had several years' experience of interacting with middle-aged men, as doctors and patients. Although the research interview context is different, often their work environment is much more stressful. The ways that the interactions were affected by the perceptions that the interviewees had of the researcher is, necessarily, a matter of conjecture but the researcher believes it is unlikely that the interviewees were unduly inhibited or that they gave misleading or contrived answers.

As can be expected among a group of professional people who were reasonably confident about themselves and their positions, their responses were largely spontaneous, there was diversity of opinion about many of the topics that arose and there were many instances where the respondents spoke with conviction and/or passion about aspects that they were particularly interested in or concerned about. Indeed, some responses contained flashes of emotion in which their opinions were

expressed with candour and contained criticism of their professional settings and the experiences on their courses.

During the interviews, interviewees gave different weightings and emphases in accordance with their interpretations of the significance of different aspects and the relevance of their courses to them. As was expected, there was a wide range of opinion expressed about many aspects of the courses, their perceptions of the future development of the profession and, indeed, their own visions of their personal futures. This is considered to be important, since the impressions that students had before and after starting their courses could, and in some cases did, vary substantially.

The interviewer was able to pose particular questions and draw attention to areas that interviewees did not spontaneously touch upon, and did so in order to ensure a sufficiently wide range of responses and opinions and a broadly comparable range of topics from each of the interviewees. Before and during each interview he read and noted the interviewees' responses to the postal questionnaire and, where desirable, posed questions that covered missing or vague responses. It was clear to the interviewer that the variety and richness of the interviewees' responses was far greater than was generated by the more confined responses to the administration of standardised instruments, especially a postal questionnaire. However, the researcher recognises that, irrespective of the skill in conducting an interview and in devising and putting the questions, on the one hand, gaps can still be left, on the other hand, the interviewer may appear to suggest answers to the interviewee. Furthermore, that such suggested responses can be considered to be tantamount to false ones.

The interviewer was aware of his impressions and feelings during the interviews. These included the ambience and suitability of the venue, and some personality aspects of the interviewees, - confidence level, 'mental set', degree of apparent interest, and curiosity level, among others. During many of the interviews he developed an impression of the overall value the interview was likely to have to the research. He experienced different levels of personal satisfaction with the way

different interviews were going and some respondents came across as 'more interesting' or 'better informants' than others. It was noticeable when interviews were going comparatively well or were somehow below what was hoped for. For example; some respondents said relatively little without being repeatedly prompted; a couple of interviewees gave 'economical responses' even with prompting, or, on the other hand, when a few interviewees gave more extensive than were necessary for the purposes of the present study. The length of the interviews and the degree of ease of the interviewees appeared not to be linked with the course they were on or to their jobs.

Two of the interviewees in particular were expansive in their answers and on several occasions in each case, wandered completely off the topic of the 'question'. This was a little disconcerting as one can become impatient and lose the thread of the dialogue. Seemingly many minutes passed before there was an appropriate opening to turn the conversation by putting a further question or making a summary comment to draw a line under the topic in question. The researcher, although an interviewer of some experience in other circumstances, appointment interviews and enquiries, for example, was aware that it was necessary to use different tactics to keep the interviewees in the right frame of mind that would encourage the richness of dialogue that was necessary for the research. Towards the end of the series of interviews the researcher felt distinctly more at ease and confident in his approach.

Transcription and Data Analysis

The term data refers to the rough materials that researchers collect from the world they are studying; they are the particulars that form the basis of analysis. Data analysis is the process of systematically searching and arranging the interview transcripts, fieldnotes and other materials to increase understanding of them and to enable what has been discovered to be communicated to others. It involves working with the data, organising them, breaking them into usable units, synthesising them, searching for patterns, discovering what is important, what is to be learned and deciding what (you) the researcher will tell others (Bogdan and Biklen, 1994: 153).

The information imparted during the interviews was extracted as discrete elements of data. As well as the elements extracted from the interview transcript, some data were impressions about the interviewees' personal characteristics, personality, attitude, demeanour, facial expressions, eye contact, dress, etcetera and noteworthy features of the environment in which the interviews took place (Bogdan and Biklen 1995: 106). These impressions of the interviewees outside of the dialogue itself, were recorded as fieldnotes, as were personal thoughts that occurred to me about my own disposition and emotions during the interviews. Thoughts that occurred after the interviews, namely, ideas about the direction of the research, initial interpretations and concerns, feelings, hunches and prejudices, were also found to be valuable. These records were found to be useful for further consideration as 'reflections'. Bogdan and Biklen (1994: 121) regard this reflective process as likely to yield beneficial insights when purposively indulged in and it has often been found to shape the future direction of research.

Audiotapes of the interviews were made into written transcripts. A 'coding frame' was devised in order to recognise, categorise and record the frequency of particular responses relevant to the objectives of the research. This is included as Appendix C. Each transcript was a complete record of the interview and each one was stored on a personal computer (PC) as a separate file. Then a file was created for each topic area/question covered in the interviews, for each of the two degrees. The 'copy' and 'paste' functions on the PC were used to extract the relevant sections to produce collated material containing the qualitative data for analysis. The material was then analysed to identify data that corresponded with each identifier to each question on the coding frame. In practice, it was found to be helpful and relatively straightforward to work from hard copy printouts, rather than directly from the computer screen.

Each identifier in a topic area/question in the coding frame was highlighted in a different colour - up to seven were needed for some of the topic areas. The highlighting was done firstly on the coding frame itself to serve as the reference and then on the topic area files. The same highlight colours were then used to show up

the sentences, phrases or key words for each identifier in each of the topic area files, thereby producing a colour-coded 'incidence recognition' picture for the set of responses to each. This made for easier recognition and enabled superficial visual comparisons in the incidence of each of the responses between the same topic/question between the two degrees. Once the visual recognition of the incidence had occurred, it was found that it helped with the more important conceptual analysis and evaluation of context and meaning.

The first five transcripts were typed verbatim, including the grammatical errors, the jargon, slang words, the umms and arrhs and occasional small talk, wisecracks and jibes. Even in one interview the recording of a diversion of several minutes when, in the interviewee's home, a black pet rabbit entered the room through a 'cat-flap' and proceeded to hop around the room until it decided to chew the cable of the tape recorder. These five full transcripts were made because of the interviewer's inexperience in qualitative interviewing and transcription and he was unsure about the extent it was acceptable to reduce the record to the crucial elements containing useful data. After guidance had been obtained from his supervisor, the later transcripts omitted the unimportant elements of the dialogues.

The printed versions were subjected to manual scrutiny and data extracted with the aid of a simple analysis tool which served as a coding frame and a reference during the interviews - see Appendix C. The analysis tool was drawn up in 'pilot' form before the interviews started and later refined after the first five interviews had taken place. This analysis tool contained a number of categories of the responses to each of the 'questions' that could be 'scored' from each of the transcripts. These items of data correspond to Hycner's 'units of meaning' relevant to each of the research questions (Hycner 1985). The analysis tool enabled responses to be categorised and summated for further consideration.

As in most instances of qualitative research the analysis of data was commenced during the fieldwork stage. In accordance with advice in much of the literature on qualitative research, as the fieldwork proceeded the researcher made judgements

about the efficacy of the data being obtained and decided that some minor modifications of the approach were desirable that would enhance the quality of the data being generated (Hammersley and Atkinson 1995: 191). Some adjustments were made to the manner in which the dialogue was conducted to try to achieve the optimum degree of rapport between the researcher and the subjects. Additional topic areas were added after the fifth and eighth interviews.

The researcher's thoughts about these topics were in part prompted by brief comments that some of the early interviewees had made spontaneously and through reflection during the typing of the transcriptions. Hammersley and Atkinson refer to this as 'progressive focusing'. The first five interviewees were not asked about 'how relevant or valuable it was to have a knowledge of nursing theory and nursing models', 'the extent to which their courses provided them with knowledge of nursing theory and models' and ' the extent to which they applied nursing theory and models in their practice'. Two further topics were added after the eighth interview, namely 'the dichotomy between generalism and specialism in nursing' and ' the relative importance of science and art in nursing'. Later, the interviewees who did not have these extra topic areas put to them, were telephoned for their responses. The views that they gave over the telephone showed no apparent differences to the range of opinions expressed during the face-to-face interviews.

The data obtained during the qualitative stage of the research that were found to be significant for understanding and making judgements about respondents' behaviour in answer to the research questions are presented and discussed in chapter 5.

Chapter Four

Looking for Patterns: Analysis of Quantitative Data

The Population

This chapter deals with the analysis of the quantitative data collected from the institution's computerised management information system and the postal questionnaire. The purpose of collecting these data was to identify and understand the characteristics and to discern the differences between the two populations who undertook the BSc in Health Studies and the BSc in Nursing Studies degrees. In particular, to discover whether patterns could be found to distinguish, on the one hand, community and hospital nurses and, on the other, between the hospital nurses who chose the alternative courses.

Aim 1. *To ascertain the professional profiles of those choosing the Health Studies and the Nursing Studies degrees, in particular of those nurses working in hospitals.*

Research questions arising:

1.1 What are the characteristics of the people who apply for these different degrees, in terms of present employment, age, educational and professional qualifications and professional history?

1.2 Are there differences in the profiles of hospital and community nurses and between hospital-based nurses on the Health Studies and Nursing Studies degrees?

The Institute's Computerised Management Information System (CMIS) contained core data on all subjects in the three cohorts selected for the research - the total potential research population. Printouts containing the following data for each of the subjects were obtained and analysed: Student PIN, Course, Relevant Year, Date of Birth, Gender, Ethnicity, Degree Course and Start Date. This data concealed the individuals' identities and complied with the requirements of the Data Protection Act licensed to the Institute.

Start Dates and Progress Rates to Graduation

Further analysis was then undertaken in an effort to tease out some of the differences between the two degree populations. The year of registration of each of the students for their degree courses was ascertained and these data were arranged separately for each of the cohorts, as shown in Table 4.1. Percentages have been rounded to whole numbers to ease perusal.

START DATES AND PROGRESS RATES TO GRADUATION

		Health Studies		Nursing Studies	
	Start Year	Persons	%	Persons	%
Graduated 1995					
	<1990	2	2%	8	11%
	1991	16	13%	18	25%
	1992	16	13%	16	22%
	1993	53	44%	25	35%
	1994	37	30%	3	4%
		124	100%	72	100%
Graduated 1996					
	<1991	11	6%	10	17%
	1992	11	6%	12	18%
	1993	48	27%	27	40%
	1994	50	28%	16	24%
	1995	60	33%	3	4%
		180	100%	68	100%
Students 1996/97					
	<1992	8	4%	7	5%
	1993	15	8%	14	10%
	1994	40	22%	27	20%
	1995	61	34%	32	24%
	1996	57	31%	56	41%
		181	100%	136	100%

* **Table 4.1**

The data clearly show that the composition of all these cohorts differs markedly from the typical three year full time degree course - when students do not receive credits for previous learning. By comparing the year of graduation with the start year, it is seen that in each case, there is considerable variation in the length of time 'on-course'. All students had between 60 and 240 points credited through previous academic achievement against 360 points for honours degree graduation.

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* A more detailed explanation about community nurses on the Health Studies degree is given under table 4.1d in Appendix D.

On both courses most students graduate after two years of part time study and a substantial number graduate after between one and three years but a minority take four years or longer. Most students who took four years or longer had a break in studies to fit in with their personal or professional lives.

These figures clearly demonstrate that there is no difference in the times taken for students to graduate on the two degree courses; a potentially important consideration for part-time students following a professional course. One can, therefore, rule out expediency as a reason for degree choice.

Current Employment

Place of Work

It was realised by the researcher that information on the work roles and workplaces of the course participants was likely to be fundamentally important to the investigation. A question requesting respondents to give their Job Title in order to elicit this information was incorporated into the postal questionnaire. Analysis of the data enabled them to be placed in hospital or community workplaces revealed the breakdown shown in Table 4.2.

WORKPLACES OF RESPONDENTS

		Community -based	Hospital -based	Education	Unemployed/ Not Given
Health Studies	**1995**	22	9	4	2
	1996	40	34	2	0
	1996/97	21	47	4	0
	Totals	**83**	**90**	**10**	**2**
Nursing Studies	**1995**	1	26	3	0
	1996	0	21	6	0
	1996/97	1	53	4	1
	Totals	**2**	**100**	**13**	**1**

[#] Table 4.2

[#] Additional data on the workplaces of respondents is displayed in Table 4.2d/4.3d in Appendix D.

The most notable finding is that there are almost as many hospital nurses taking the Health Studies as the Nursing Studies degree. Secondly, only two respondents working in the community, a Community Psychiatric Nurse and a Family Planning Nurse, were taking the Nursing Studies degree. The number of hospital-based respondents on both courses rose year on year, except for a dip in 1996 in the graduates of the Nursing Studies course. The doubling of community nursing graduates on the Health Studies degree in 1996 was due to a 'bulge' of Occupational Health Nurses, Practice Nurses and Nurse Practitioners who topped-up their post-registration diplomas. Their numbers fell in the 1996/97 student cohort.

A small number of respondents, 23 (7%) across all the cohorts of both degrees, 10 on the Health Studies and 13 on the Nursing Studies degree, were employed solely in educational roles and had no responsibility for direct patient care. It had become clear that the groups that were making the critical decisions about course choice and were instrumental in the Health Studies degree becoming more popular were involved in direct patient care and that the great majority of them were working in hospital settings. Accordingly, data from those who were solely employed in educational institutions, the two respondents who were unemployed, the one who failed to answer the question, and the two community nurses on the Nursing Studies degree were excluded from further analysis. Their exclusion at this stage made it easier to concentrate on identifying the variables between the groups of highest importance.

Job Titles and Promotion

Professional job titles were sufficiently explicit to differentiate whether the respondent was hospital-based or community-based. Hospital-based job titles revealed in the analysis were: Staff Nurse, Ward Sister, Clinical Specialist and a few variants that could be placed in one of these categories. These being Charge Nurse - the male equivalent to Ward Sister; Primary Nurse, Associate Nurse and Enrolled Nurse - all equivalent to Staff Nurse. Community-based job titles were; District Nurse, Health Visitor, Occupational Health Nurse, Practice Nurse, Nurse

Practitioner, Community Psychiatric Nurse and Macmillan Nurse. The data are displayed in Table 4.3.

Some Occupational Health Nurses are employed in hospitals to provide a service for employees. They do not work directly with patients and work in environments providing services similar to OHNs employed in other large organisations. These respondents are included in the community-based group. Some posts in hospitals are entitled Nurse Practitioner. They are usually in clinical specialist posts. However, all Nurse Practitioners among the respondents included other information in their questionnaires to identify and place them in the community-based group.

JOB TITLES AT START OF COURSE

Hospital-based

		Staff Nurse		Ward Sister		Clinical Specialist	
Health Studies	**90**	**60**	**68%**	**18**	**20%**	**12**	**13%**
Nursing Studies	**100**	**69**	**69%**	**24**	**24%**	**7**	**7%**

Community-based

		District Nurse	Health Visitor	Occ H'lth Nurse	Practice Nurse	Nurse Pract'r	Other
Health Studies	**83**	**12 14%**	**4 5%**	**26 31%**	**32 38%**	**5 6%**	**2 3%**

Table 4.3

It will be noted that the percentages of the hospital-based nurses on the two courses are similar for Staff Nurses and Ward Sisters. There is a clear difference in Clinical Specialists between the courses of 6% but caution is due about the interpretation of this because of the comparatively small numbers involved. Among the community nurses, all OHNs, HVs and Nurse Practitioners have grades equivalent to Ward Sister and perhaps higher, indeed many may consider themselves to be Clinical Specialists. District Nurses are not so clear cut, most probably equate to Ward Sister in terms of salary and professional status but some

are more equivalent to Staff Nurse. Taken overall, community nurses as a group are 'more senior' than the hospital nurses.

Current Grades and Promotions

Respondents were also asked to give their grades at the start of their courses and their current grade - that is, at the time of questionnaire completion. The data collated from the respondents are displayed in Table 4.4.

STAFF PROMOTED AND PRESENT GRADES

		<---------Hospital-based-------->									<----------Community-based------>								
		Prom'd		Latest Grades								Prom'd		Latest Grades							
Health Studies				D	E	F	G	H	I	I+	NR			D	E	F	G	H	I	I+	NR
1995	**n= 9**	6	67%	0	2	3	1	0	2	0	1	**n=22**	13	59%	0	1	3	7	7	2	0	2
1996	**n=34**	22	65%	3	8	8	7	7	0	0	1	**n=40**	25	62%	0	0	3	12	18	2	3	2
1996/97	**n=47**	19	40%	10	10	9	9	7	1	1	0	**n=21**	7	47%	0	1	2	8	3	1	3	3
Totals	**90**	**47**	**52%**	**13**	**20**	**20**	**17**	**14**	**3**	**1**	**2**	**83**	**45**	**50%**	**0**	**2**	**8**	**27**	**28**	**5**	**6**	**7**
Nursing Studies																					
1995	**n=26**	14	70%	1	2	6	11	4	1	1	0	**n= 1**	1	50%	0	0	0	1	0	0	0	1
1996	**n=21**	19	82%	0	4	7	6	3	1	0	0	**n= 0**	0		0	0	0	0	0	0	0	0
1996/97	**n=53**	29	55%	8	11	18	10	4	0	1	1	**n= 1**	0		0	0	0	0	0	0	0	0
Totals	**100**	**62**	**62%**	**9**	**17**	**30**	**27**	**11**	**2**	**2**	**2**		**1**	**50%**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

NR = Not relevant

Table 4.4

The grades shown are pay grades used by the national Pay Review Body, where A is the lowest and I the highest in terms of salary. Grades A to C (not shown) are only used for Health Care Assistants and unqualified staff, who were not eligible for the degree courses in question. Grade D is mainly used for the immediate post-registration period and the majority of Staff Nurses move upwards within months or very few years. Grade D is also sometimes used for 'returners' who come back to nursing after a career break, but again, not for long. Grades are not strictly linked to job titles and Staff Nurses ranged from grades D to G. Ward Sisters ranged from grades F to H generally with a few on grade I. The 'grade' I+ was used for respondents who stated 'above I' or who gave a salary of more than the I

grade salary. A few respondents gave a salary, rather than a grade - these were translated to the relevant pay grade. They were also asked whether they had been promoted to a more desirable but not higher graded post. The column NR, (not relevant) contains those who were full time students or unemployed and any where no grade was given.

The data show that the majority have been promoted according to the criteria set in the question (to a higher grade or a more desirable appointment), except for the 47% of community-based staff on the Health Studies 1996/97 student cohort. This does not appear to be of particular significance in view of the small number of just seven individuals. It will be noted that exactly one half of community nurses were promoted. The highest concentration among community staff occurs in grades G and H, with none in grade D and only two in grade E. This finding is consistent with the higher professional seniority accorded to community nurses with their additional professional qualification.

For hospital staff, the highest concentration spans E to G. There are also some in grade D, notably in the latest cohorts of both degrees. During the transcription of data from the questionnaires, it was noted that the D grades were mainly those who completed Project 2000 courses between 1993 and 1996. The data for hospital staff show that a slightly greater number of those who chose the Nursing Studies degree have been promoted, compared to those who took the Health Studies degree.

Among hospital nurses, their job titles at the start of their courses were very similar, with two thirds occupying the lowest qualified rank of Staff Nurse. The remainder were Ward Sisters and Clinical Specialists. Promotions can therefore be between job titles (eg Staff Nurse to Ward Sister) or within the same job title, as for instance, one Staff Nurse post to another.

Sixty-two percent on the Nursing Studies course had been promoted, ten percent more than for those on the Health Studies course (52%). Whether this has

something to do with those responsible for making appointments favouring those who chose the Nursing Studies degree or whether it is related to the attitudes of the respondents in some way would require further exploration. The proportion of Health Studies nurses on the two lowest (Staff Nurse) grades of D and E, is eleven percent higher (37%), compared with 26% on the Nursing Studies course.

Table 4.4 shows the number of nurses in each grade at the time of data collection and the number and percentage of those who had been promoted since they started their courses. Around 90% of Institute students are part time and attend on one day a week during term time. Approximately one half are known to have time from their working hours to attend. The others attend in their normal weekly days off. These arrangements mean that there is little interference to their 'normal' career progression. Indeed, it is likely that most graduates and students on degree courses will gain more rapid promotion than the majority of non-graduates.

Apart from the exceptionally successful Nursing Studies 1996 graduates, the differences in the numbers promoted are greater on both courses from the 1995 graduates down to the 1996/97 students. This is to be expected and it was noted during transcription of data from the questionnaires onto the analysis frame that most promotions were from Staff Nurse to Ward Sister. This occurred both after graduation and also in the current student cohorts.

Age at Commencement of Course

Table 4.5 shows the age ranges of students in 5 year periods for the commencement of their courses. Analysis of the data showed that community nurses were significantly older than hospital-based nurses on both courses. Only 18 (21%) of community nurses were 30 years of age or younger, whereas 59 (65%) of hospital nurses on the Health Studies course and 63 (63%) on the Nursing Studies course were aged 30 or under. The age distribution of hospital nurses on the two courses was noted to be very similar over the three 'cohort' years.

AGE IN YEARS AT COMMENCEMENT OF COURSE

	Totals	Under 25	26 - 30	31 - 35	36 - 40	41 & Over
Health Studies						
a) Community Nurses	**83**	**1 1%**	**17 20%**	**15 18%**	**21 25%**	**29 35%**
b) Hospital Nurses	**90**	**20 22%**	**39 43%**	**16 17%**	**8 9%**	**7 8%**
Nursing Studies						
c) Hospital Nurses	**100**	**26 26%**	**37 37%**	**17 17%**	**12 12%**	**8 8%#**
d) a, b and c combined	**273**	**47 17%**	**93 34%**	**48 18%**	**41 15%**	**44 16%**

 # Table 4.5

The data also show a rising percentage of community nurses across the three highest age bands, whereas the converse is found among hospital nurses on both courses. The generally older community nurses, 78% aged 31 or older, is probably a reflection of several factors. In many cases community nurses change from hospital to community after many years of working in hospitals and not infrequently when they return to work after a career break.

The UKCC collects national statistics from the live register of nurses in similar 5 year age bands. Percentages for 1998 in the age bands that approximate to Table 4.5 are included below to provide a comparison (UKCC 1998).

	Under 25	25 – 29	30 – 34	35 – 39	40 and over
All parts of the Register	0.3%	11%	17%	19%	50%

The age profile of the degree course students differs markedly from the national nursing population. The community nurse profile (Table 4.5a) has the closest fit but the hospital nurses, (Table 4.5 b and c), have a much younger age profile than the national data. The differences may be due to multiple reasons, including younger nurses may envisage greater benefits for their career in obtaining a degree, they are likely to have fewer family commitments which might be a

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Additional data on the workplaces of respondents is displayed in Table 4.5d in Appendix D.

disincentive and they may find it easier to gain the support of managers since costs are likely to be lower and they have the potentially longer service to give.

Educational Qualifications

The educational qualifications of the respondents who returned the questionnaires were analysed and each individual was placed in one of three categories which represent the status of admission to their degree course.

The three categories were: (1) two or more Advanced level passes in the General Certificate of Education or equivalent, including foreign qualifications, higher education qualifications such as certificates, diplomas, but excluding those in category 2, degrees and Open University unit credits; (2) professional nursing qualifications, either specialist post-registration certificates and diplomas (eg in Health Visiting, District Nursing or Occupational Health Nursing) but excluding teaching qualifications which were accepted in lieu of A levels, or the recent Project 2000 pre-registration diplomas. (3) those with 1 A level and, or O levels or equivalent, or less. All individuals falling in category 3 were required to take an entrance test approved by the Joint Matriculation Board (JMB) since the University of Manchester was the validating and degree awarding university. A satisfactory score in an entrance test enabled admission. The data are displayed in Table 4.6. Two further points should be borne in mind. Candidates with the necessary A levels or equivalents, were placed in this category, (Cat 1), regardless of whether they also held professional qualifications for category 2.

EDUCATIONAL ENTRANCE QUALIFICATIONS

	Totals	Cat 1 - A levels		Cat 2 - Prof Quals		Cat 3 - Entr'ce Test	
		a	b	c	d	e	f
Health Studies							
Community Nurses	83	37	44%	23	28%	23	28%
Hospital Nurses	90	48	54%	2	2%	40	44%
Nursing Studies							
Hospital Nurses	100	70	70%	0		30	30%

[#] Table 4.6

[#] A full analysis of the Educational Entrance Qualifications for each of the cohort years is displayed in Table 4.6d in appendix D.

The data in table 4.6 reveal that community nurses have a different educational profile from hospital nurses. Community nurses have lower general educational qualifications, only 44% have A levels. This difference was found to be largely due to the older age profile of the community nurses, as was seen in table 4.5.

In the hospital-based element of the Health Studies course 54% possessed A level or equivalent - 10% higher than the community-based element but 16% lower than the 70% of hospital nurses on the Nursing Studies course. The hospital-based element of the Health Studies course was more likely to rely on gaining admission through the entrance test - 44% of students, compared to 30% on the Nursing Studies course.

The older age of the community nurses places their secondary education at a time when a much smaller proportion completed A levels or equivalent qualifications and this can be considered to be at least partially responsible. Also, at the time of their entry to nurse training a lower educational entrance standard was set for nurse training.

Twenty-three community-based candidates (28%), were admitted to the Health Studies course by virtue of holding an acceptable professional qualification, compared to only 2 (2%) of hospital-based candidates. No candidates were admitted to the Nursing Studies course by holding specialist professional qualifications. There was no policy in operation that would account for any of the differences that have been revealed and it is very unlikely that those who were responsible for admitting students were using a covert selection strategy.

Professional Qualifications

Subjects were asked to give their professional qualifications with the year of their first statutory registration with the relevant statutory body, United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the three former General Nursing Councils. The data generated from the respondents

are displayed in Table 4.7, Professional Qualifications and in Table 4.8, Decade of Qualification.

In Table 4.7 community nurses on the Health Studies course show different characteristics from the hospital nurses on both courses. Only 30 (36%) of respondents out of 83 community nurses were admitted solely on the general parts of the register, compared to 76% of hospital nurses on the Health Studies course and 75% on the Nursing Studies course. As expected, a far higher proportion of community nurses held a post-registration specialist community nursing qualification- 38 (46%) of respondents out of a total of 83. The most prevalent of these qualifications was in Occupational Health Nursing, the second most prevalent was District Nursing. A Health Visiting qualification was the least common of the three. A few respondents had two of these qualifications. This low percentage is due to the comparatively high proportion of Practice Nurses in the sample for whom no formally (UKCC) recognised qualification currently exists.

PROFESSIONAL QUALIFICATIONS

	Totals	General Register only a		General plus other part of Register b		Gen + Comm Specialist Qualification c		Other part of Register only d	
Health Studies									
Community Nurses	83	30	36%	14	17%	38	46%	1	1%
Hospital Nurses	90	68	76%	14	16%	3	3%	5	6%
Nursing Studies									
Hospital Nurses	100	75	75%	13	13%	2	2%	10	10%

#Table 4.7

Column b of Table 4.7 contains the data of respondents who were on the general and one or more other parts of the register. The commonest of the other parts was midwifery, followed by mental nursing, with the fewest in children's nursing. It will be noted that the percentages in each of the cohorts is similar, ranging between 13% to 17%.

A full analysis of the Professional Qualifications for each of the cohort years is displayed in Table 4.7d in appendix D.

A small minority of 16 respondents across the three groups, were registered in other than general nursing; namely mental nursing and children's nursing. It can be seen in column d that among hospital nurses on both courses, the numbers are highest for the latest cohort in each case. It was noted that 13 of these 16 respondents were Project 2000 diplomates. The Project 2000 philosophy is to provide a Common Foundation Programme for the first half of the three year courses, before the specialist training component is undertaken that determines which branch of nursing individuals qualify in. It is meant to avoid the need and temptation to take subsequent pre-registration courses, thereby helping to reduce drift across the specialisations and to cut down on expensive retraining. It is notable that the distribution of professional qualifications of the hospital nurses on both of the degree courses is strikingly similar.

Professional History

Decade of qualification

As a group, community nurses trained and gained their initial qualification, almost all of them in general nursing, significantly earlier than hospital nurses, with no fewer than 45 of the 83 subjects qualifying in the 1960s and 1970s - refer to Table 4.8. This contrasts strongly with hospital nurses, of whom 17 out of 100 (17%) on the Nursing Studies course and only 11 out of 90 (12%), on the Health Studies course and qualified in 1979 or earlier.

DECADE OF QUALIFICATION

	Totals	1960s		1970s		1980s		1990s	
Health Studies									
Community Nurses	83	10	12%	35	42%	37	46%	1	1%
Hospital Nurses	90	2	2%	9	10%	41	46%	38	42%
Nursing Studies									
Hospital Nurses	100	2	2%	15	15%	53	53%	33	33%

 # Table 4.8

Comparing the totals of all three cohort years of hospital nurses on the two courses across all of the decades, reveals that those who chose the Health Studies course have been qualified for a shorter time overall than those who chose the

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A full analysis of Decade of Qualification for each of the cohort years is displayed in Table 4.8d in Appendix D.

Nursing Studies course. This is most marked for those who qualified the most recently. A significantly higher proportion of those on the Health Studies course, 38 (42%), have qualified since 1990, compared with 33 (33%) on the Nursing Studies course.

Number of Years of Professional Work Experience

Respondents were asked to state the length of time they had worked since first qualifying to the nearest whole year. These data, displayed in table 4.9 were collected to exclude any time that may have been taken as career breaks for child-rearing or other reasons. A number of respondents were Enrolled Nurses (Second Level) for some years before they became Registered General Nurses (First Level). In these cases the dates of the earlier registration were used.

NUMBER OF YEARS OF PROFESSIONAL WORK

	Totals	21 & Over		16 - 20		11 - 15		6 - 10		Under 5	
Health Studies											
Community	**83**	**19**	**23%**	**28**	**34%**	**19**	**23%**	**15**	**18%**	**2**	**2%**
Hospital	**90**	**4**	**4%**	**6**	**7%**	**13**	**14%**	**35**	**39%**	**32**	**36%**
Nursing Studies											
Hospital	**100**	**5**	**5%**	**10**	**10%**	**22**	**22%**	**38**	**38%**	**20**	**20%**

*** Table 4.9**

The data again demonstrate a marked contrast between the number of years of professional work experience undertaken since initial qualification between community and hospital nurses. Over half of community nurses have had in excess of 15 years, in spite of the fact that most will have taken one year out of work for a course in Health Visiting, District Nursing or Occupational Health Nursing. Ten percent had 10 years experience or less.

The earlier years of qualification and the much lower amount of professional work experience of hospital-based nurses in comparison to community nurses largely reflects the age difference between the nurses in the two sectors. Only one

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A full analysis of the data is displayed in the corresponding table in appendix D.

in five of the hospital nurses on the Nursing Studies course had more than 15 years experience and over one half of them had ten years or less. Hospital nurses on the Health Studies course had the least amount of work experience -only 11% had more than 15 years experience but no less than 75% had ten years or less. This is most marked in the under 5 years category where there is a 16% difference. This disparity in work experience among hospital-based nurses on the two courses is in part due to the higher number of Project 2000 qualifiers choosing the Health Studies course but the reason why they made their choice is not known.

Choice of Degree and Its Professional Utility

The researcher wished to obtain data from the postal questionnaire that addressed Research Aim 2. *To compare course selection with its utility for practice,* and in particular the following research questions:

2.1 How much care did students take in choosing their degree course?

2.3 How valuable did students find their degree course to be in terms of their current and intended professional roles?

The answers provide insight into the amount of thought that went into the choice of degree and the value that graduates and students placed upon the degree of their choice in the context of their work.

DEGREE SELECTION FACTORS

		Considered other Deg? Yes	No	Pos for Own Degr	Neg for Other Degr	Both (c) and (d)	Neut/No Comment	Logical Progress
		A	b	c	d	e	f	g
Health Studies								
Community-based	83	17 20%	66 80%	30 36%	2 2%	7 8%	17 20%	28 34%
Hospital-based	90	25 28%	65 72%	52 58%	3 3%	25 28%	10 11%	0
Nursing Studies								
Hospital-based	100	30 30%	70 70%	31 31%	0	5 5%	40 40%	35 35%

Table 4.10

Table 4.10 contains the responses to the following questions as worded in the questionnaire. The responses to the question, '*Did you give serious consideration to taking other degree courses within the Institute?*' required a Yes/No answer.

The responses are in columns a and b. Responses to the question: '*Why did you choose the particular course that you are taking, or have completed?*' provided data for columns c, e (where appropriate), and columns f and g. Respondents were asked to give up to three reasons. The great majority gave only one reason. Around half gave two reasons, while very few gave three reasons or none. Regardless of how many positive reasons a respondent gave, they were recorded as a single datum, either in column c (where no negative reason was given to consideration of the alternative degree), or in column e, when they also gave a negative reason for **not** choosing the alternative degree.

The data recorded in column d represent respondents who gave a clearly negative reason for not choosing the alternative degree (i.e. for Health Studies participants who made one or more negative comments about the Nursing Studies degree - or vice-versa). The data recorded in column e represent respondents who made **both** positive comments about their own degree and negative comments about the alternative degree. A number of respondents made comments that were neutral, that is, unclassifiable as either positive or negative, for instance, 'Good for my career', 'To prove my ability', 'The Institute has a high reputation'. If a respondent provided **only** neutral comment, the datum was recorded in column f. The 'logical progress' data in column g represent the respondents who clearly stated that they regarded the degree course that they had chosen as being a logical or more natural, or rational follow-on from a course that they had taken previously. All such responses have been recorded in column g, irrespective of any other responses that they made and which have been recorded in other columns of Table 4.10.

[A brief explanation about the term 'logical progress' is necessary. This refers to the relationship between sub-degree and degree courses within the Institute's programme of courses, the intentions that were 'designed into' the Health Studies and Nursing Studies degree courses and hence the

Institute's perception of the 'best fit' of a given certificate or diploma to one of the two degree courses in question. The BSc in Health Studies was designed by the same (Health) Curriculum Development Group (CDG) responsible for the range of community nursing diplomas and certificates (in Occupational Health Nursing, Practice Nursing and for Nurse Practitioners). The BSc in Health Studies was designed with community nurses in mind and the third level modules on the degree course were considered to be particularly suitable for those with these qualifications. All these courses were shown as being related in the Prospectus. A similar situation pertained to the post-registration diplomas in nursing and the pre-registration Project 2000 diploma and their relationship to the BSc in Nursing Studies, which was the responsibility of a different (Nursing) CDG. Students progressing from nursing diplomas were exempt from the otherwise compulsory second level modules in nursing – those without a nursing diploma, such as pre-Project 2000 registered nurses were required to take the second level modules. The BSc in Nursing Studies was designed with hospital nurses in mind. Nurses who progressed to the degree courses in accordance with the design intentions and who had the maximum CATs points and module exemptions were regarded as making a logical progression.]

Marked differences were found in the responses of the three groups, as shown in the data shown in Table 4.10. The great majority of respondents in all groups gave no consideration to taking an alternative course to their own. Community nurses were the most positive with four out of five making this response, while one in three of these indicated that it was a logical progression from their earlier courses. Their comments included (their course was), "a natural follow-on from my Occupational Health nursing diploma", "more closely related to my previous study", "most relevant to my Practice Nurse certificate" and "two thirds of the modules I did on my earlier (Nurse Practitioner) course".

Of the hospital nurses, those on the Nursing Studies degree gave similar responses to the community nurses. Seven out of ten hospital nurses on the Health Studies degree only considered this course, many of them indicating that it was broader in scope or that they wanted a health orientated course. Perhaps not surprisingly, none of them said their choice of course represented a logical progression, indeed it can be considered to be a divergent choice compared to the Institute's rationale for course progression as published in the prospectus. Their comments included, "I wanted a broader-based degree", "it is not just nursing-related" and "I wanted a wider knowledge content".

The choices made by the community nurses on the Health Studies course and the hospital nurses on the Nursing Studies course were consistent with a more narrowly focused career path but the hospital nurses who chose the Health Studies

degree appear to be diffident about the Nursing Studies course and/or to have given themselves a greater option for a broader career.

In looking at the three different groups - the community nurses and the two groups of hospital nurses, the most strikingly different group is the hospital nurses on the Health Studies degree. They are by far the strongest in their positive comments about their degree, (column c), and in making both positive comments about the Health Studies degree and negative comments about the Nursing Studies degree (column e). It will be seen that none of them commented that their choice of degree represented 'logical progress'. Perhaps they were aware of the Institute's expectation, suggested in its Prospectus, that they would progress to the Nursing Studies degree and were making a 'deviant' choice. However, the degree they chose cannot be said to be an illogical choice, given that there has been a move towards making nursing a more health-oriented profession.

Nursing Studies degree respondents gave the highest number of neutral comments. Only six of the total of 40 gave no comment. The overall numbers of community nurses on the Health Studies degree and hospital nurses on the Nursing Studies degree making 'logical progress' comments are virtually the same. However, for the latest students in each of the groups, the numbers are diverging from the earlier years' graduates. In the case of the community nurses, it is largely due to the bulge of Occupational Health Nurses and Nurse Practitioners having completed their top-up degrees, referred to earlier. No reason has been identified for the increase in those on the Nursing Studies course.

Responses to the question on degree choice were unequivocal. Across all three groups only a minority had considered taking a degree course other than the one they chose. Only 20% of community nurses had given consideration to taking a course other than the Health Studies degree. This is not surprising, since the course was initially designed with their professional needs in mind. However, two surprises emerged. Firstly, the results about consideration of other degrees from the two groups of hospital nurses were almost identical. Seven out of ten on both

the Health Studies and the Nursing Studies degree courses had not considered taking a course other than their own. There was clearly little or no ambivalence or indecision over choice.

More surprising was the revelation that there were marked differences between the two groups about the extent of positive reasons towards their own degree course and negative reasons given for rejecting the alternative degree course. The least positive towards their own degree came from hospital nurses on the Nursing Studies degree at only 36%. Not far behind were community nurses on the Health Studies degree (44%). But no fewer than 86% of hospital nurses on the Health Studies degree gave positive reasons for their choice of course. They also gave by far the highest number of negative comments against the Nursing Studies degree (31%). Only 11% of this group made neutral or no comments, whereas 40% of hospital nurses made neutral or no comments.

It is also interesting that, although no question was put on the issue, the same proportion, over one third, of community nurses on the Health Studies degree and hospital nurses on the Nursing Studies degree indicated that their choices represented 'logical progress' from a previously taken course. Not a single response was received about this from hospital nurses on the Health Studies degree. However, none of the hospital nurses who chose the Health Studies degree made any allusion to the logicality of their choice of course and it was clear that many of them were aware that choosing the Health Studies course was a deliberate decision away from the pathway that was designed for them. In this respect they can be deemed to have been divergent, if not deviant. It does, therefore, have to be concluded that they constitute the 'critical' group as far as this research is concerned.

Degree Course Valuation of Utility

Subjects were asked in the questionnaire to give a value to the utility of their degree course in terms of their current and intended professional roles.

They were asked to tick one of four boxes corresponding to the following statements: Box A: 'Vital and indispensable'; Box B: 'High value and relevance'; Box C 'Moderate value and relevance'; Box D 'Low value and relevance'. The data generated from respondents' replies are displayed in Table 4.11.

Hospital nurses on the Nursing Studies degree are the most satisfied of the three groups. When a and b are summed they show a 'highly satisfied' rating of 81%. This compares with 70% for community nurses on the Health Studies degree and 67% for hospital nurses on the Health Studies degree. The 14% disparity between

DEGREE COURSE VALUATION OF UTILITY

		Vital and Indispen-sable a		High Value and Relevance b		Moderate Value and Relevance c		Low Value and Relevance d		Not Answered	
Health Studies											
Community-based	**83**	**21**	**25%**	**37**	**46%**	**22**	**27%**	**1**	**2%**	**1**	**2%**
Hospital-based	**90**	**13**	**14%**	**48**	**53%**	**27**	**30%**	**1**	**2%**	**1**	**1%**
Nursing Studies											
Hospital-based	**100**	**35**	**35%**	**46**	**46%**	**13**	**13%**	**2**	**2%**	**4**	**4%**

Table 4.11

the two groups of hospital nurses suggests that those on the Nursing Studies degree believe that their course is more relevant and valuable to their practice than their counterparts who took the Health Studies degree.

The Group of Primary Interest

The purpose of the quantitative stage of the research was to discern differences between the three groups of nurses and whether they formed patterns that would assist in making decisions in planning and conducting the qualitative stage. Overall conclusions from analysis and comparison of the data between the community nurses and hospital nurses has shown community nurses to be markedly different from the two groups of hospital nurses. The reasons for most, if not all, of the differences that have been revealed between community nurses and hospital nurses have been commented on in each of the areas that have been

analysed. This being so, it was decided to confine the quantitative phase of the research to a comparison of the two groups of hospital nurses, those who chose Health Studies and their counterparts who chose the Nursing Studies degree.

It is hospital-based nurses who are making the crucial choice of whether to take the broader and more openly health-oriented degree or the more nursing and hospital-focused degree. The analysed biographical and professional history data reveal that hospital-based nurses on the Health Studies degree display a divergent tendency, compared to their counterparts on the Nursing Studies degree. This is clearly demonstrated by the responses to the questions on degree choice and degree utility. It was decided, therefore, that the group of primary interest was the **hospital-based nurses who chose the Health Studies degree** and it was necessary to compare them in the qualitative stage of the research with the hospital nurses who chose the Nursing Studies degree course. Accordingly, community nurses were omitted from the qualitative phase of the research.

Chapter Five

Revelation of Motives and Opinions: Analysis of Qualitative Data

The analysis of quantitative data dealt with in the previous chapter revealed some significant characteristics that enabled the three groups to be differentiated in a number of ways. There were some areas where there were no differences. These are not discussed except to emphasize that there was no difference in the length of time students took to complete their courses, irrespective of their field of work and their choice of course. It had been decided that community nurses would not be included in the qualitative stage of the research because none of them chose the Nursing Studies course and they were unique in most of the key characteristics.

When it was hypothesized that the hospital nurses on the Nursing Studies degree were following a more logically or naturally progressive course and that hospital nurses on the Health Studies course were making a more divergent choice, a clearer picture emerged. Hospital nurses on the Health Studies degree were found to:

1. be less likely to have A level entrance, fewer general educational qualifications and to be reliant on the entrance test for admission to their course;
2. be more recently qualified and to have less professional work experience;
3. have a lower incidence of promotion to higher grades or better posts;
4. make positive comments about their own degree and to make negative comments about the other (Nursing Studies) degree.
5. be less satisfied with their course in preparing them for their current and future professional roles.

The analysis of the quantitative data has shown that the hospital nurses on the Health Studies degree are sufficiently different in several respects from hospital nurses on the Nursing Studies degree and community nurses on the Health Studies degree. Whereas the hospital nurses on the Nursing Studies degree course and the community nurses display strong tendencies to have selected their courses on the basis of direct progression - the most straightforward extension of their earlier studies - often reflecting their satisfaction with their previous courses, the hospital nurses on the Health Studies degree have, in many, if not all cases, made a divergent decision. They made the greatest number of positive comments about their own degree course as well as making the greatest number of negative comments about the other, the Nursing Studies degree course. However, hospital nurses on the Health Studies course were also the least satisfied of all three groups with their course.

Although Health Studies participants had the strongest opinions of the three groups in making their course selection decisions, they are also the group that was most dissatisfied with their course in preparing them for their present and future professional roles. Two possibilities might be behind this. They could be more thoughtful than the other two groups in giving consideration to the other alternatives and therefore, more discriminating in their decision making or they may have a greater tendency towards negative views and perceptions about nursing and their future careers. The level of course dissatisfaction was not explored in the interviews since it could not be a reason for their choice of course.

The impressions and attitudes of hospital-based participants on the Health Studies course about the current and future position of nursing, especially hospital nursing, may differ from the impressions and attitudes of those in the other two groups. A comparison of hospital nurses on the two degree courses at this stage in the research, bearing in mind that there were two compulsory modules on the Nursing Studies degree and that there was no necessity to take any nursing modules for the Health Studies degree, suggests that those who chose the Nursing Studies course could be more closely affiliated to traditional nursing values of

altruism and personal 'humane' relationships with patients, especially nurturing and empathy, than their Health Studies counterparts.

Conversely, hospital nurses who chose the Health Studies degree have made a divergent decision about their choice of course and are looking outside the confines of the nursing domain, having rejected the inclusion of the specific nursing modules. This raised the possibilities that they may have a weaker allegiance to the profession of nursing and that they may be more inclined to challenge traditional nursing values than Nursing Studies participants. It also suggests that they might be more ready to look for an alternative career opening.

Issues for Exploration Through Interviews

The researcher hypothesized that when nurses chose their particular degree courses they were likely to be influenced by factors integral to their everyday work experiences that they interpreted according to their core beliefs, by their assumptions of the likely development of nursing and of their assessment of their own potential within the profession. Accordingly, the following four areas were identified as being potentially fruitful for investigation:

* the modules that students chose to make up their courses
* belief, or otherwise, in the importance of nursing theory and nursing models to underpin and guide practice;
* attitude towards 'generalism' and 'specialism' as an orientation or focus for practice;
* belief in the relative importance of art compared to science as a basis for practice;
* identification of current and future issues linked to professionalism and their perceptions of future developments.

Outline of Method

Qualitative data was generated from a purposively selected sample of fifteen graduates and students. A semi-structured approach was used in the face to face

interviews between the researcher and the interviewees, using a framework of the key points to be covered that served as guidance during the interviews that later was also used as a coding frame for extracting and analysing the data. All of the interviewees were nurses working in direct patient care in hospitals, seven of whom were Health Studies graduates or students and eight were Nursing Studies graduates or students.

The Sample

Salient personal characteristics of the nurses who were interviewed and whose responses form the material in this chapter are shown in table 5.1.

INTERVIEWEE COHORTS WITH KEY CHARACTERISTICS

Interview Ref No	Gender	Age at Cse Start	Start Year	Grad Year	Job Title	Pay Grade
H1	F	31	1991	1995	Ward Sister	F
H2	M	28	1995	1998	Staff Nurse	E
H3	F	48	1992	1995	Clin Spec'st	H
H4	F	28	1994	1998	Clin Spec'st	H
H5	F	37	1996	1999	Clin Spec'st	I
H6	F	24	1996	1999	Staff Nurse	D
H7	F	28	1994	1998	Ward Sister	G
N1	M	42	1991	1995	Charge Nse	H
N2	F	37	1991	1997	Ward Sister	F
N3	M	40	1996	2000	Charge Nse	G
N4	F	37	1995	1996	Ward Sister	F
N5	F	23	1996	1999	Staff Nurse	D
N6	M	39	1993	1996	Clin Spec'st	G
N7	F	28	1993	1996	Ward Sister	F
N8	F	31	1994	1999	Staff Nurse	F

Notes: 1. Charge Nurse is the male equivalent of Ward Sister.
2. In Grad Year column 1999 and 2000 are estimates.

Table 5.1

The interviewees have been given reference numbers, for example H1, N3, where H denotes the Health Studies degree course and N the Nursing Studies degree course. Samples of comments made by the interviewees are identified by their reference numbers to enable readers to gain a better insight and to be able to appreciate the contextual circumstances pertaining to the individuals making the responses. The smallness of the sample for the qualitative stage, while sufficient for indicative purposes, means that the general representativeness is in doubt

(Hammersley and Atkinson 1995: 42). Caution is therefore necessary in generalising the findings.

Choice of Degree: Attitudes to Academic Content and Career Orientation

In addition to focusing on the four research areas referred to above, it was decided to augment and extend the data on degree course selection that had been obtained in response to questions in the postal questionnaire that were analysed and discussed in the preceding chapter. The first of these was:

2.2 What reasons did interviewees give for their degree course choice?

The interviewees were asked to describe what sort of things they considered before deciding to take their degree course. A few spontaneously mentioned a number of factors that they had considered and discussed them in some detail. The interviewer had previously identified four different possible reasons, namely, 'academic challenge'; 'demands of the role/to develop higher level practice'; 'colleagues influence'; 'career advancement/professional ambition/prestige'. When interviewees gave only one answer that could be put into a category, or if they were unduly hesitant, the interviewer put one or more further questions to enquire whether they had considered other reasons. Interviewees were not asked to give the order of importance to them when two or more factors were mentioned and so the researcher has made no inferences from the order in which the factors were given. The responses are displayed in table 5.2.

Would you describe what sort of things you considered that lead to your decision to take your degree course?

a) academic challenge		b) demands of role/ to develop higher level of practice		c) work colleagues influence		d) career advancement/ambition/ professional prestige	
HS	**NS**	**HS**	**NS**	**HS**	**NS**	**HS**	**NS**
2	6	2	2	0	2	6	6

Table 5.2

The key finding is clearly the difference between the two groups in the proportion who positively considered that academic challenge was a reason for undertaking

their degree course. Six of the eight Nursing Studies participants believe that deeper academic insights into nursing theory is required to have a successful and fulfilling career in nursing. Their statements included,

N2: *Definitely academic challenge... the level 3 nursing concepts module, I knew it was going to be hard academically.*

N4: *I suppose it was a sense of academic challenge – and achievement....my interest is in models of nursing, standards and theory – that's why I took the BSc in Nursing Studies. I'm continuing that on the Masters in Nursing.*

N7: *I was conscious of wanting to prove my (academic) ability. Nursing was what I wanted to do, especially care of the elderly and nursing theory.*

They knew that the Nursing Studies degree, with compulsory modules in nursing theory, was designed to do that, whereas the Health Studies degree definitely does not. They regarded the nursing theory modules as being particularly demanding in terms of the reading and assignments and, therefore, as a distinct academic challenge. Only two Health Studies participants cited 'academic challenge' yet, in terms of the requirement to pass modules to the value of 120 points at level three, the Health Studies degree is just as academically demanding, but in subjects other than nursing.

Next, respondents were directly asked to give their reasons for choosing the particular degree that they did. As was expected, the two groups gave some markedly different answers. The researcher did not prompt by giving possible reasons. The responses fell into the four categories displayed in table 5.3.

Why did you choose the (Health or Nursing) Studies degree rather than another option?

a)	b)	c)	d)
gave little consideration before deciding	wanted broader/ more focal degree	did not want Nursing/Health degree	definite/possible career change
HS / NS	**HS / NS**	**HS / NS**	**HS / NS**
4 / 5	5 / 3	4 / 2	5 / 0

Table 5.3

The most striking feature of the data is the finding that five of the Health Studies interviewees mentioned a definite or possible change of career, whereas no-one on the Nursing Studies degree did. Four of these five and one other, also said they wanted a broader degree and regarded the Nursing Studies course as too narrow and focused upon nursing per se. They believed either that the Health Studies degree would help them to enter another career or that having a nursing degree would hamper a career change. They appeared to be intent about keeping their options open for the future; for example:

***H5**: I felt that the Nursing degree was too nursing-oriented, especially if I want to change direction in the future.*

***H6**: Because I didn't want to stay in nursing and doing nursing studies would keep me in the position I'm in. Health Studies allows you to branch out and I would be able to change jobs more easily.*

The positive (column b) and negative attitudes (column c) towards the two courses were obviously linked and most interviewees made both positive and negative comments. Health Studies interviewees were more likely to have firm views about the courses. Six of the seven Health Studies interviewees gave responses that fell into these categories, against only four of the eight Nursing Studies interviewees. From the two courses combined, eight interviewees related to the scope of their course (column b). The five from Health Studies specifically referred to the wider range of module options on their degree, compared to the Nursing Studies degree. Three of these Health Studies respondents spoke positively about the broader scope of their course, the other two mentioned the 'narrowness' of the Nursing Studies course. As shown in column c, four Health Studies interviewees expressed negative comments about the Nursing Studies degree, compared to just two Nursing studies interviewees who were negative about the Health Studies course.

***H3**: I think the Health Studies degree encompassed better what I was seeing and doing in my work. It was broader-based.*

***H7**: The reason being I assumed that the nursing degree would be very nursing-focused.*

Nine of the total respondents clearly indicated that they had given little consideration to taking the alternative degree course prior to making their decision (column a). The five Nursing Studies interviewees considered that they were making a logical progression from their earlier courses and saw no reason for choosing an alternative. Three of these were aware of the differences between the courses and were sure that they did not want the Health Studies degree (recorded in column c.), the other two were unaware of the differences but were strongly biased towards the Nursing Studies degree. Only one of the four Health Studies respondents who were negative towards the Nursing Studies degree was unaware of the differences between the two courses. Two responses under column a were:

N1: I can't remember exactly why I took the Nursing rather than the Health Studies but I'm a clinician through and through.

N8: I couldn't give a particular reason. I can't think of anything else apart from I was just thinking Nursing Studies.

Three interviewees deliberately chose the Nursing Studies degree because of its particular focus on nursing.

N3: Nursing is my chosen career. I want Nursing to be written across the top of the certificate when I get it, if I get it. Although Health Studies is just as valuable, it isn't as obvious.

N7: Because I wanted to remain clinical, I wasn't interested in management degrees. I looked at Health Studies because that's what people here were doing but I didn't think it was close enough to what I am doing here.

In the case of N3, he wanted also to be able to demonstrate publicly his achievement in gaining a degree in nursing and not in another subject. He gave a strong impression of dedication and loyalty to nursing and he expressed the view that joining the profession had given him an opportunity to better himself and have a career, and that he was unlikely to have had an alternative.

Further to the responses made specifically about their choice of degree, later in their interviews five Nursing Studies participants made comments that suggested they were oriented towards the humanistic and vocational (altruistic) model of professionalism. Only one used the word vocation but comments of others pointed in this direction.

N2: *If you don't have deep commitment you can't really care for people – you'll never make a good nurse. Not just your priorities and what's technically correct. It's the human side that matters – patients' have to know that what you do is really for them.*

N3: *You have to want to do the job – often putting in more than you're paid to do – correction – not often, usually. You have to have the motivation that comes from within you- it's a personal thing.*

N5: *Nursing is more of a vocation than a profession, more than just a job. For me it's much more a sharing of yourself with your patients' I suppose I mean. That's what makes it all so draining- you're putting so much into it.*

Although Health Studies respondents usually referred to **caring** as an essential ingredient of nursing, as a group, their comments did not suggest they were as deeply committed in the vocational sense as those on the Nursing Studies course.

H4: *To like caring for people you have to be a certain type of person, doing your best for people within your capabilities, intellectual and personal (sic).*

H5: *It's a caring profession, ... treating other people as individuals, ... involving good communication between nurses and patients.*

On this evidence Nursing Studies respondents appeared to espouse the 'traditional' orientation to nursing as an altruistic vocation and loyalty to its traditional humanistic values, consistent with the 'functionalist' model of professionalism (Davies 1992).

Returning to the responses to the question about why they chose their particular degree course, three of the four Health Studies interviewees who said they did not want a degree in nursing, (table 5.3c), appeared to express an 'anti-nursing' or 'anti-specialist' attitude, as can be seen in the two responses below. Their position was to favour a broader transferable range of knowledge and skills, conferring

greater flexibility within looser boundaries, and with a greater external vision about future developments; for example:

***H1**: There was another reason why I didn't want to do the nursing studies degree. There was a lot of emphasis on nursing theory. I did not like the sound of this. I didn't want this in depth - I was just put-off.*

***H6**: I think the decision was already made for me in the sense that I knew my reasons for doing a degree - and my reasons were not nursing, they were broader than that.*

These three nurses plus two others (column d) are thinking positively about a future career change. Their outlook is consistent with the contemporary prevalence of 'portfolio careers' rather than the earlier narrower vision of one career 'for life'.

The conclusion that one arrives at from analysing the responses to the two questions relating to degree course choice is that most members of both groups made decisions which suited their particular circumstances, orientations and visions of their futures within or outside of nursing. There was no suggestion that anyone had made an inappropriate choice, had been badly advised or had simply drifted onto the wrong course. The Health Studies group chose their course because of the broader scope of the subjects (modules) available to them, compared with the Nursing Studies course. They saw that possession of this degree offered a better opportunity of a career change outside of nursing.

The Nursing Studies participants were positively oriented towards nursing and wanted to study it in depth, acknowledging that this meant a greater academic challenge, especially at level 3. Their choice of degree was largely based on their intention to pursue a career in nursing, none raising the possibility of a change in career direction.

Module Choice and Conceptual and Perceptual Aspects of Nursing

The researcher believed that comparisons between Health Studies and Nursing Studies participants in their choice of modules that they took to make up their degrees may reveal differences in conceptual and perceptual orientations to nursing. If differences were found, what were their opinions about the efficacy and benefits arising from their courses and how well did their courses fit their professional needs?

It was conjectured that differences would be found in the way that nurses on the two degree courses conceived nursing theory and the value and the importance that they placed upon approaches and orientation to nursing practice. It was decided to investigate this by seeking to elicit their values, opinions, attitudes and behaviour concerning nursing theory and nursing models and a range of topical professional issues to determine whether there were distinct differences between the two degree populations.

Research Aim 3 and the research questions arising from were formulated to address these areas:

Aim 3. *To determine whether there are differences in module patterns, values, opinions, attitudes and behaviour between hospital nurses on the Health Studies and the Nursing Studies degrees that may be related to their choice of degree.*

Research questions arising:

3.1 Are there differences in the patterns of module types in the make up of the two degrees?

3.2 Do graduates/students have different opinions and attitudes about nursing theory and models?

3.3 Are there differences in the perceptions that graduates/students have about professionalism and professional issues?

Module Selection

The researcher had a hunch that Nursing Studies participants would be found to have a clearer understanding of the relationship of the subject content of the modules that they took to their roles, certainly in respect of the nursing modules, compared to Health Studies participants. This was supported by the evidence, as the sample of comments relating to table 5.5 illustrates.

When the research was started, a sizeable minority of interviewees were still students and had not completed their module choices to graduation. At interview, those who had not completed their degree requirement were asked about definite and possible further module selections and the majority of these students had decided which modules to take. Three had not done so; two of them will take a break in studies for personal reasons. Printouts of their latest course transcripts were obtained from the Institute registry for confirmation of the modules that had credited and those for which they were currently registered. Analysis of these profiles was undertaken. The data that make up the groups and categories are shown in table 5.4.

The modules were separated into two groups and eight categories. The **structural group** concerns the fundamental administrative make-up of all of the degrees run within the Institute. The three categories within this group are; **degree core** consisting of modules that determine which degree is awarded, with regulations that stipulate the minimum number of modules that must be taken. There is no maximum number that may be selected. The **common compulsory** category contains other essential modules, which for the two degrees in question are one research methods module and the dissertation. The third category in this group is; **common optional** consisting of modules which can be chosen by any student to make up their degree. The second group is the **academic subject** group.

The **professional** modules comprise the degree core modules, especially nursing and others such as complementary therapies, health promotion and counselling. Social and life sciences and research methods are self explanatory. The **other**

category for these particular degrees comprises management, education and information technology modules.

COMPARISON OF MODULE SELECTIONS

			<Main Module Group>			<------Academic Subject Group------>				
	Pers'l Code	Mod Credit	Deg Core	Com Comp	Com Opt'l	Professi onal	Social Sci	Life Sci	Res'rch Method	Other
	a	b	c	d	e	f	g	h	i	j
Health Studies	H1	2	3	2	5	5	3	0	1	1
	H2	8	1	2	1	2	1	0	1	0
	H3	5	6	2	0	4	1	2	1	0
	H4	4	4	2	1	3	1	1	1	1
	H5*	4	(2)		(2)	(1)	(2)	(1)		
	H6	8	1	2	2	1	1	1	2	0
	H7	4	2	2	3	3	3	1	1	1
	Totals	**35**	**18**	**12**	**12**	**18**	**10**	**5**	**7**	**3**
	Means	**5**	**3**	**2**	**2**	**3**	**2**	**1**	**1**	**0.5**
Nursing Studies	N1	4	3	2	4	4	0	4	1	0
	N2	2	3	2	4	6	1	1	1	1
	N3*	4	(1)	0	(2)	(2)			(1)	
	N4	6	2	2	2	3	1	0	1	1
	N5*	7	(1)	(1)	(2)	(1)	(1)	(1)	(1)	
	N6	8	2	2	1	3	1	0	1	0
	N7	4	2	2	4	5	1	1	1	0
	N8	4	4	2	3	5	2	1	1	0
	Totals	**39**	**17**	**12**	**18**	**26**	**6**	**7**	**6**	**2**
	Means	**5**	**3**	**2**	**3**	**4.3**	**1**	**1**	**1**	**0.3**

Table 5.4

* denotes student status, therefore full module choice not known
(n) these students' modules excluded from totals and means

Each of the modules chosen by the students was placed into one category in each of the two groups. The table also includes the personal code identifier for each of the interviewees and the number of module credits awarded to them for previous academic achievement. It will be noted that the ranges (2-8), and the means (5), are the same for the two courses. Each module credit represents 30/40 points of the 360 minimum that students require to graduate. Column c 'degree core' category represents modules essential for the award of the degree for which the student is registered. There were a minimum of two modules to be taken, unless dispensation was given in recognition that an individual had already completed study and passed an equivalent standard on an earlier programme. Students H2 and H6 were granted dispensation. It is seen that the mean number of three modules in this category was common to both degrees. As is to be expected, there

was no difference in the holdings of two in the 'common compulsory' category. The 'common optional' category consists of modules that form part of both degrees. The mean for the Health Studies students was two, against three modules for the Nursing Studies students.

Adding the means of column b 'module credits' and columns c to e, the modules actually taken on the courses, reveals that Health Studies students accumulated twelve module credits compared to thirteen for the Nursing Studies students. The explanation for this is that students on the Health Studies course were more likely to have taken level 3 modules at a weighting of 40 credit points; an option open to all students, whereas Nursing Studies students were more likely to have taken standard 30 point modules and to have taken an extra module. The regulations allow for more than 360 points to be accumulated within a degree course, including the points credited for prior learning.

Under the 'academic subject group', 'professional subject' modules in column f, includes nursing per se, complementary therapies (hypnosis, massage, etc), health education, health promotion and counselling. Analysis shows that Health Studies students have taken a range of one to five modules, with a mean of three, compared to Nursing Studies students, who have a range of three to six, with a mean of 4.3. Health Studies students show a greater interest in 'social sciences' than Nursing Studies students but there are virtually no differences between the two student groups in 'life sciences', 'research methods, and 'other' modules, (management, education and information technology).

The most significant findings are that hospital-based Nursing Studies students took one and a half professional modules more on average than Health Studies students and were also more likely to have taken an extra module beyond the minimum for graduation. This suggests that hospital nurses who chose the Nursing Studies degree may relate more closely to their patients and are probably more vocationally oriented to nursing than those who chose the Health Studies degree.

Attitudes To Nursing Theory And Nursing Models

This section addresses the following research question:

3.2 Do graduates/students have different opinions and attitudes about nursing theory and models?

The principal difference between the two degrees is that the Nursing Studies programme contains compulsory modules devoted to a study of nursing theory and nursing models, one at level two and at least one of the three available at level three, whereas the Health Studies degree does not. If they so wished, students on the Heath Studies degree could take the level two module but none of the level three modules. In fact, none of them did.

Academically minded nurses have, from time to time, introduced aspects of nursing theory and methodology in nursing practice, particularly over the past thirty years. Much of it was originated in the United States of America (Henderson 1966, Rogers 1970, Fawcett 1978), where academic departments in universities have been established far longer than in the United Kingdom. The intention of the academics was to augment the theoretical underpinnings of nursing practice and to endow it with academic respectability in the quest for greater professionalisation. However, the great majority of nursing practitioners have not been educated at the higher education level and do not appreciate the significance of what was, and is, being attempted in the name of nursing. Many clinical nurses tended to be sceptical about the motives of academic nurses and were unconvinced by arguments in favour of basing nursing practice on theoretical constructions and even, in many cases on demonstrable research findings, now often termed 'evidence-based' nursing.

The majority of nurses know little about what has been researched and published and many who have an awareness would argue that it does not consist of a theory of nursing as such. Nursing models are personalised versions of problem solving models, that is personalised by the designer of the particular model that usually bears the persons name, eg Roper et al (1980) model of the 'activities of daily

living'. They are based on diagnosing or recognising an individual client's nursing problems, planning to solve them, executing the plan through a series of nursing measures (interventions) and evaluating the results of the nursing measures - thereby re-diagnosing the client's problem/s. In this way the process can be said to be cyclical in nature.

Some models involve greater complexity, if not sophistication, than others. Even in their comparatively short life, they have tended to wax and wane in popularity and nurses and hospitals may have an allegiance to one or the other. Resistance to the imposition of changes to 'traditional' practice has been widespread and large numbers of nurses abstained from adopting them. Many of the succession of the new approaches were heavily 'proceduralised' and were accompanied by copious form-filling which was advocated as essential record keeping and for quality audit. In many cases the documentary processes were reduced to ritualistic clichéd comments or box-ticking. Even initially enthusiastic advocates suffered from fatigue and the innovations became the subject of decay and disuse.

Interviewees from both of the courses were asked about the relevance and value of having a knowledge of nursing theory and of nursing models. Their aggregated responses are shown in table 5.5.

How relevant or valuable do you think it is to have a knowledge of nursing theory and nursing models?

a) very relevant/valuable		b) moderately relevant/valuable		c) of little or no relevance/value	
HS	**NS**	**HS**	**NS**	**HS**	**NS**
2	4	2	3	3	1

Table 5.5

Twice as many Nursing Studies as Health Studies interviewees believe it is very relevant/valuable to have a knowledge of nursing theories and nursing models. Three times as many Health Studies interviewees as Nursing Studies interviewees believe they have little or no relevance or value. The statements categorised as 'very relevant/ valuable' are typically:

***H1**: I think that they are always very useful. I may be biased but I enjoyed doing nursing models on the diploma and I helped them to introduce Orem's (model at my hospital).*
***N2**: Very. I am a believer in having a sound framework for planning and decision-making. Theory helps you to think through your own rationale. Using a model helps to keep an eye on priorities and makes it less likely you will omit things.*

The statements made by those who said they were of no or little relevance are reproduced below.

***H3**: Not very. I think a little more of nursing models than nursing theory. But they are student nurse requirements.*
***H4**: I haven't had to use nursing models for any of my work, they are of no relevance.*

Two of the respondents acknowledged that it was necessary for pre-registration students to have to learn about nursing theory and nursing models but presumably only to acquaint them with theory and models rather than to be thoroughly conversant and to integrate them into their nursing practice. This is a commonly found attitude to nursing theory and nursing models throughout the entire nursing workforce.

The next question interviewees were asked attempted to discover whether their expressed attitudes to nursing models and nursing theory had been internalised and operationalised. It is, of course, well known that there is often a weak correlation between what people say they believe in, and indeed may say that they do, and what they actually do in practice. Individuals may interpret the question as a normative one; that is, recognise what answer they should give, or be expected to give, and feel under some pressure to comply in their answer. Interviewees were asked the question shown below followed by; *it would be helpful if you can give an example.* The researcher added this rider to maximise the chance of being given a thoughtful and honest answer. However, because of the lack of clarity in their responses to this question, it was also necessary in around half of the interviewees for the researcher to ask them to state whether the extent to which they used nursing theory and nursing models was *'usually or frequently'*;

'occasionally or when necessary' or *'rarely or never'*. Interviewees were also asked to differentiate between nursing theory and nursing models when it was unclear whether they were referring to one or another, or both. Refer to Table 5.6.

To what extent do you apply nursing theory or/and nursing models in your practice?

a) usually/frequently	b) occasionally/when necessary	c) rarely/never
HS / NS	**HS / NS**	**HS / NS**
1 / 2	2 / 3	4 / 3

Table 5.6

The statements made by the three respondents who said that they utilised nursing theory and, or nursing models frequently are:

***H7**: I apply nursing models frequently as I'm ward-based. We apply Roy's care model as a framework - but it's not fully put into action.*
***N2**: All the time to some extent. Not that I favour slavish obedience for the sake of it. I encourage their (theory and models) use on my ward because I'm sure a higher standard of care is achieved.*

The following is a sample of those who rarely or never utilised nursing theory or nursing models:

***H4**: I'm not into using nursing theory. Nursing models no, not really. I certainly cannot say I look them up and deliberately use them. Whatever I do it's already there. In my job, I don't tend to document very much, I don't think it's very important for me.*
***N3**: No, not as such. I do however work in a systematic way. I like to think I have a methodical approach to my work.*

The data shown in table 5.8 reveal that Nursing Studies participants are more likely to use nursing theory and nursing models than Health Studies participants but the extent to which both groups have rejected the practicality of utilising them in their practice was unexpected. While it is less surprising to find that Health Studies respondents appear to be more indifferent, Nursing Studies respondents were expected to have even more favourable attitudes to both nursing theory and

nursing models and to have made greater efforts to utilise them in their nursing practice. The fact that, on the Nursing Studies course there are two compulsory modules that are solely concerned with nursing theory and models and it is these that constitute the main difference between the two degrees, was thought to be one of the reasons for choosing this degree. These modules were designed and taught, with frequent reference to their application to practice with the intention of encouraging students to implement them in their work. This will surely be considered to be a disappointing finding that in this respect it has failed.

Professionalism and Professional Issues in Nursing

A number of professional values, opinions and attitudes were considered to be potentially important and likely to be influential in determining the choice of degree course. The following research question is addressed in the next two sections:

> *3.3 Are there differences in the perceptions that graduates/students have about professionalism and professional issues?*

Two Ideological Dichotomies in Nursing: Determination of Subjects' Views

Over the past few years there have been debates about two aspects of nursing, that for some, represent ideological dichotomies. One of the two dichotomies is 'generalism' versus 'specialism' in terms of orientation to, knowledge of, and skills in, patient care (White 1988). The second is whether nursing is predominantly an art or a science. Protagonists for a particular belief may tend to maximise their own belief and marginalize the alternative position. Many can be expected to take a hybrid position, believing that both are important or desirable. The researcher expected that the range of views would be likely to span the distance between the two extremes and represent a continuum.

Generalism versus Specialism

The generalist/specialist issue became evident in the nineteen-seventies as a result of nationally organised clinical courses for general hospital nurses by the then,

Joint Board for Clinical Nursing Studies. Before this time there were very few specialists working in general hospitals, although specialist community nurses had been the norm for over thirty years. Since the advent of these courses an increasing number of clinical specialists have been trained in an increasing number of specialisms, due to the expansion of medical knowledge, the complexity of monitoring, diagnostic and therapeutic procedures and the demands for greater accountability for interventions.

There has been a further increase in support for clinical specialists since 1995, when the United Kingdom Central Council for Nursing, Midwifery and Health Visiting published criteria for the training of clinical specialists as part of its Post Registration Education for Practice Project (PREP) requirement (UKCC 1995). The number of nurses who are regarded by themselves and their employers as clinical specialists is undoubtedly growing now but no official record is kept at this time to provide evidence of actual numbers. It is a matter of speculation about what level of support might exist for continuing the trend towards increasing the number of clinical specialists. Is there a body of opinion that believes that it could go too far in forsaking a common core of nursing activity that all patients require and that all nurses should provide? Do supporters of generalism feel apprehensive that clinical specialists may try to drop this core nursing and expect others (generalists) to provide it? Could there be divergence of opinion about the issue from hospital-based participants on the two different courses and, if so, could it be influential in their choice of course?

The researcher had no pre-conceptions about which positions might be taken by nurses on the two courses about either of these dichotomies. As will be seen, distinct differences emerged in the data generated by the two groups of hospital nurses in response to questions about these dichotomies, which are more pronounced in the specialism versus generalism argument, the question and the distributed data for which are in table 5.7.

There has been an issue about 'generalism' versus 'specialism' in nursing over the past few years that appears to have more focussed since the introduction of Nurse Specialists. Some argue that the profession still needs generalists, while others advocate the development of more specialists. Where do you stand on the apparent dichotomy?

a) Pro-Generalism HS / NS	b) Pro-Specialism HS / NS	c) Neutral / both HS / NS	d) Undecided / uncommitted HS / NS
1 / 4	6 / 2	0 / 2	0 / 0

Table 5.7

The interviewees were split along course lines. Nursing Studies subjects were pro-generalist by a ratio of four to one, whilst Health Studies subjects favoured specialists by a ratio of three to one. It is perhaps to be expected that the Health Studies group should be more supportive of specialists since three out of the seven in the group have clinical specialist job titles but the group's support for specialists was significantly stronger than 3 : 7. All of the Health Studies interviewees were unequivocally in favour of one or the other but two of the Nursing Studies group were undecided. A selection of the responses from those giving categorical answers are illustrated below.

Pro-Generalism

N1: You can say that most nurses are generalists but with more and more nurses claiming they are specialists the balance is likely to change. You have to have a sound generalist base. I'm a generalist and proud of it.

N5: Actually, we had this debate yesterday at work. There are people who have been on the (same) ward for years and obviously their knowledge is going to be very specialised and that's fine if that's what you want to do. However, I think that a broader nursing knowledge base is an advantage and I suggested that we have more open contracts that allow nurses to move round to different wards, say, each year or every 6 months. Their knowledge would be wider and their attitudes would be broader as well. Then perhaps the actual patient care would be better.

Pro-Specialism

H3: I suppose I am a specialist and have been for most of my career. To me a generalist can only know a comparatively little about the broad range of conditions and treatments. It's all very well in the early days of your career until you decide what you are most

interested in - then you have to specialise to understand in depth and to be of most use to your patients or clients.

***H5**: I'm a very specialist nurse in a very specialist hospital. I do agree that we become very narrow. It's important to try to look at other areas and discuss developments outside of your own field as well. I've (had) quite a wide range of experience but some nurses specialise too early before they have a sufficiently wide range of experience.*

Health Studies students were more likely to be in specialist roles prior to enrolment and as a group appear to be more independent in outlook, more willing to take risks and be more likely to leave nursing. It is not possible to determine to what extent the strong support for generalism on the Nursing Studies course was present among the participants prior to the start of their course. It is possible that many of these interviewees were inclined towards this view before enrolment but it can only be conjecture whether this may have been a factor in them choosing this course. If so, it seems likely that any inclination would be increased as a result of course experience, particularly when undertaking the nursing theory modules. These modules can be said to have a bias towards generalism in a vocational and humanitarian sense. Members of the teaching team responsible for these modules also ran the communication skills and the counselling modules and this could well have been instrumental in setting a culture which favoured generalism.

Art and Science in Nursing

The art versus science issue was recognised long before the generalist/specialist one and can be traced back to the earliest formal nurse training scheme devised by Florence Nightingale. In those early days nursing was more of an art than a science but over the generations the increasing importance of scientific principles of nursing practice has been recognised by the incorporation of social and behavioural science as well as biological science. The sweeping advances in medical science in the last two decades, in particular, have stirred up the issue about the relative importance of both.

There are different ways of conceptualising art in nursing. The 'traditional' approach has considered the art of nursing to encompass intuitive acts within the social, cultural and spiritual domains – comforting behaviour (Roper et al 1980). It is also considered to be an added dimension born of experience a skill in the sensitivity of applying scientific principles to care. The goal of the science of nursing is understanding, whereas the goal of the art of nursing is skill (Yura and Walsh 1978).

The question that concerned the art and the science of nursing was put immediately after the generalism/specialism one. As can be seen by the aggregated data in table 5.8, the only area of difference between the groups was in those who believed that the art of, or within, nursing was more important than the science, of, or within nursing. Typical comments made by those who supported one or the other side of the dichotomy are reproduced below.

Nursing can be said to be based upon art and science but there are differences to be found among nurses and others on the relative importance of each of these underpinning components. What is your opinion of the relative importance of the 'art' side and the 'science' side of nursing?

a) Pro-Art HS / NS	b) Pro-Science HS / NS	c) Of equal importance HS / NS	d) Undecided/uncommitted HS / NS
2 / 4	1 / 1	4 / 3	0 / 0

Table 5.8

Pro-Art

N3: It probably depends on your job. There are some highly technical nursing jobs that depend on science more than art but for me and the majority, the art-based elements are more important. They are the human face of nursing. Patients need good rapport with their nurses, whatever speciality they are in.

Pro-Science

H4: I think it's getting more based on scientific knowledge. In my field I know more than the junior doctors. I have nursing skills and medical knowledge as well. I have to say that the science side is of greater importance. But the art side is something we can't neglect - we need communication and counselling skills for example.

Equal in importance

N7. I think I'm in the middle. A lot of what I do are skills that I've learnt from role models and experience – counselling and personal skills – very much an art. But then there are the technicalities (sic) the understanding – surgery, medication and that sort of stuff – that's the science side.

Half of the nurses on both courses made the point that both art in nursing and science in nursing were crucial and were not prepared to separate them. Whilst recognising that the numbers involved are extremely small, there appears to be some indication that Nursing Studies participants were more likely to place art at a higher level of importance than science. Taking the generalism versus specialism dichotomy and art versus science together, there was a slight tendency that Nursing Studies participants were more likely to support generalism and the art of nursing. However, there was not a similar positive relationship between specialism and science among Health Studies participants.

Perceptions of Major Professional Issues

3.3 Are there differences in the perceptions that graduates/students have about professionalism and professional issues?

It is known that there are different notions and orientations to professionalism among nurses, some with strongly held opinions, while others are luke warm, if not negative about professionalism and related matters. The researcher decided to raise some issues without directly referring to either professionalism or professionalisation. The researcher wanted the respondents to talk about issues that were real to them, rather than abstract academic perspectives. The following questions were put: *How do you see the nursing profession developing over the next few years?* And; *What major issues have to be confronted and overcome?*

The interviewees were prompted when necessary to obtain a wider coverage of the issues. The data have been extracted and grouped to relate to the current situation and expectations or predictions for the future. Comments expressed about the current situation were separated into positive and negative and those

about the future were separated into optimistic and pessimistic. Many comments were neutral in tone, these are not shown, neither are 'not sure' responses. The data are shown in table 5.9.

How do you see the nursing profession developing over the next few years?

What major issues have to be confronted/overcome?

	<-Issues linked to Professionalisation and Professionalism->					**<-------Other Issues------->**		
	a) relationships with doctors	b) autonomy of nurses	c) prof structure/ de-skill'g/HCAs	d) professional cohesion	e) Reg Nurse staffing	f) conditions of service	g) public image	h) **Totals**
	HS / NS	**HS / NS**	**HS / NS**	**HS / NS**	**HS / NS**	**HS / NS**	**HS / NS**	**HS / NS**
CURRENT								
Positive	3 / 3	2 / 4	1 / 2	0 / 0	0 / 3	0 / 0	1 / 3	**7 / 15**
Negative	3 / 2	5 / 3	4 / 3	3 / 2	4 / 2	2 / 2	2 / 1	**23 / 15**
FUTURE								
Optimistic	4 / 6	3 / 4	0 / 0	0 / 0	0 / 1	0 / 0	0 / 3	**7 / 14**
Pessimistic	3 / 2	2 / 2	6 / 4	5 / 2	5 / 4	3 / 3	2 / 0	**26 / 17**

Table 5.9

Five distinguishable groupings of issues of professionalisation and professionalism were raised by the interviewees (columns a to e). The researcher took professionalisation to mean the *status project* for the advancement of the profession, recognised by a collective mobility project (Larson 1977) and the ability to perform and control particular skilled work (Freidson 1994). Professionalism was taken to mean *the improvement and maintenance of quality practice* embodied by affirmation of expertise (Larson 1977) and seeing oneself as a member of a profession and behaving professionally in relation to clients and colleagues (Helsby 1999).

Only one respondent mentioned the term professionalism and this was in an erroneous connotation, none mentioned professionalisation by name. However, it was possible to infer the context and meaning of most of what the respondents said in respect of the two terms. Examples being:

Professionalisation

H1: *We (in nursing) seem to be stuck. We need to expand our role but it will be a long time before we get more autonomy because doctors will not want to give up any of their status.*

N4: *We are trying to move forward towards being recognised as a true profession – but we need to recognise ourselves first. We have to convince ourselves as (sic) that first – as professionals. More autonomy in practice is essential. We need to make our own decisions and stand by them - and we need to base our decisions on a firm research base. Education is what can distinguish ourselves (sic) as a profession.*

Professionalism

N1: *I'm worried that the professional nurse will become a paper-pusher rather than a doer and that clinical skills, even basic clinical skills, will be devalued even further.*

N3: *The Nurse Practitioners are becoming more advanced and their role is more defined. We expect the junior nurses to be more self-sufficient. Many of the Project 2000 nurses are doing quite well with their increased academic knowledge and professional outlook.*

'Relationships with the medical profession' (25 distinct comments), 'autonomy of nurses' (24), and 'professional structure/deskilling and Health Care Assistants' (20) were revealed in *Table 5.9* to be the three issues of greatest concern. With regard to relationships with doctors, current positive opinions almost matched negative opinions in both groups. On the same topic, optimism about better future relationships with doctors also exceeded pessimistic predictions, by three to one in the Nursing Studies group but by a majority of just one among Health Studies respondents, being, optimism : pessimism 4 to 3, compared with 3 to 1 in the Nursing studies group. There was only one issue, 'autonomy of nurses', where optimism for the future exceeded pessimism among Health Studies respondents but this was only by 3 to 2. On all other issues the reverse was the case, although the numbers involved were small,they certainly appear to indicate that pessimism exceeds optimism in Health Studies respondents, compared to Nursing Studies respondents.

With regard to the issue of autonomy, four Nursing Studies respondents were currently content in this respect, whereas five Health Studies respondents were explicit that they were denied sufficient decision-making power. The main reasons given were that they were being constrained by doctors, who were defensive and self-protectionist. Current negative and future pessimistic statements by interviewees included:

H2: *Doctors do not want to lose their status, especially to nurses....they want to hold onto their authority- I do not see that changing.*

H5: *We continue to be handmaidens.....the medical profession like being in power and they want to retain it.*

N8: *Nurses are not allowed to make the decisions they should (about patient care) .....I think it will stay the way it is.*

Two Health Studies respondents suggested that nurses did not deserve or were unready to assume more power, referring to lack of knowledge on the part of nurses and that some nurses shunned taking on greater responsibility through apprehension about the consequences of making errors.

H4: *Most nurses have had insufficient education to make the sort of decisions that greater autonomy needs. And too many nurses change their minds too often about what decisions they should take – that's partly lack knowledge but also a culture thing.*

H6: *Only a few nurses can be fully autonomous, mostly on critical care units. Most nurses on wards don't know enough.*

However, optimism for the future gain in decision-making power and eventual autonomy was marginally greater than declared pessimism among Health Studies respondents and much greater, by 5 to 2 among Nursing Studies respondents.

Taking 'relationships with medical staff' together with 'autonomy of nurses', which the interviewees regarded as closely linked, it would appear, if their predictions materialise, these major issues will be ameliorated. However, given the long standing rivalries and manifestations of occupational closure (Parkin 1979, Witz 1990), the degree of optimism expressed may well turn out to be ill-

founded. One reason for exercising caution about the future of doctor-nurse relationships is that the two issues of inter-professional relationships and autonomy are not essentially interdependent. Some who expressed satisfaction with their relationships with doctors were thinking more of the social contact, feelings of mutual reliance and team spirit, even bonding, which although undeniably important, is somewhat different from the collective matter of inter-professional distribution and sharing of authority, responsibility and professional equality. Two samples of comments show contrasting relationships with doctors:

***H6**: Personally I've never had a problem with doctor. On here (Intensive Care Unit) we are all part of a team. If a doctor is busy I'll help and do their job. If I'm busy I get them to get on with what I should do. Most (doctors) are willing and it works both ways. As long as everyone understands this, especially the house-officers (junior doctors) we won't have a problem.*

***H7**: We have a strong relationship with medics- not confrontational but we will be if necessary. We are quite authoritarian and assertive at times- especially on the surgical ward if we have been waiting for a medic .There's a lot of grey there, so in that respect we have to have a very good relationship because we are taking things forward.*

***N5**: Elderly consultants still have a very negative view of nursing. When they see us doing something that they think should be the exclusive domain of doctors they put the pressure on nurses not to do it but if its something they don't particularly want to do, they encourage the handover.*

The third most important area, in terms of the number of comments made, concerned the professional nursing structure, embracing role changes, relinquishment of some nursing skills, relationships between direct patient carers and nursing managers and, the most contentious, the increasing use and dependence on Health Care Assistants (HCAs). It was often implied that the growing reliance on HCAs for the bulk of 'hands-on' nursing is displacing Registered Nurses from roles and tasks that 'they are best at' and distancing them from patients. Some said that this was 'de-skilling' nurses in areas fundamental to nursing. While one can appreciate the relevance of the argument for having a high proportion of Registered Nurses in the workforce, with their higher level of

knowledge and skills, the respondents may have been supporting this as a strategy of occupational closure, especially since only one (Nursing Studies) interviewee explicitly said that standards of care in her workplace were unsatisfactory.

Five interviewees, three Health Studies and two Nursing Studies, were concerned about a present lack of professional cohesion. They either said or implied that nurses were lacking in understanding the need for professional solidarity, of being 'woolly', indecisive or of changing their minds too often. It is somewhat worrying that no-one was optimistic that this situation will change for the better and seven thought it would get worse. Twice as many Health Studies than Nursing Studies interviewees were pessimistic about the issue. Nobody made a positive comment that suggested professional solidarity.

Staffing levels of Registered Nurses was the fourth most frequently mentioned topic, with nineteen comments overall. Currently, twice as many on the Health Studies course were dissatisfied compared with respondents on the Nursing Studies course. Only one, a Nursing Studies respondent, was optimistic that things would improve. Five Health Studies and four Nursing Studies respondents thought the dilution of Registered Nurses to HCAs would worsen. This finding is not surprising and closely matches reports about managers deliberately weakening the dilution, coupled with RN shortages, which is causing serious problems of recruitment and retention. Four negative comments were made about conditions of service, other than staffing levels. The same respondents, plus two others, were also pessimistic about the future. The split between the courses was even in both cases. Seven commented about the public image of nursing. Most Nursing Studies respondents thought that the image was 'good', whereas most Health Studies respondents said it was 'bad'.

The responses overall have been quantified and are shown as totals in column g. When the Health Studies and Nursing Studies groups are compared, the findings support the impression that Health Studies interviewees are less satisfied with the current position in nursing. They made half as many positive statements as

Nursing Studies interviewees, (seven compared with fourteen). They also made more negative statements, (23 against 15 by Nursing Studies interviewees). Looking to the future, Nursing Studies interviewees were more optimistic. Taking optimistic statements into account, more than twice as many Nursing Studies than Health Studies interviewees thought that the overall position would improve. However, both groups made more pessimistic comments than optimistic ones. Again Health Studies interviewees were much more pessimistic than Nursing Studies interviewees, making over three times as many pessimistic than optimistic comments (23 : 7). Nursing Studies interviewees were only slightly more pessimistic (17 : 14).

The overall findings lend further support to the earlier indications that Nursing Studies participants' currently strike a 'balance' between positive and negative factors and their opinions and attitudes are less confrontational. They appear to hold with the **altruistic** (vocational) model of professionalism (Davies 1992). The Health Studies participants, by comparison, are more disaffected and appear more closely aligned to the **power** approach model (Freidson 1994), or perhaps the **process** model (Freidson 1994).

The Nursing Studies participants' opinions and attitudes are also consistent with Hugman's (1991) contention that professions, including nursing and social work, are feminine-oriented and committed to caring ***for*** clients. The Health Studies participants, however, on the face of it, appear less inclined to be, but instead, appear to have more in common with masculine-oriented professions like medicine, that, according to Hugman, care ***about*** clients, and are, therefore, more impersonal (Hugman 1991: 9-12). The gist of Hugman's contention is that objectivity prevails in eliciting problems and devising solutions, wherein responsibility is taken for prescription and treatment but the practitioner is inclined to be less concerned about the clients' emotional, social and spiritual needs.

Health Studies participants have a greater tendency to recognise a need for further advances in professionalisation but believe it is less likely than Nursing Studies participants. They suffer comparatively greater frustration, including about the lack of cohesion among nurses. They are more likely to submit to their lack of satisfaction and frustration and leave nursing.

Chapter Six

Findings and Conclusions

This investigation has sought to identify factors that influenced nurses in making their decisions about which of two honours degree courses they undertook in a given institution. Nurses employed in the community, as expected, almost exclusively chose the BSc in Health Studies which was specifically designed for them. Nurses who work in hospitals, however, did not conform to expectations that they would choose the Nursing Studies degree, over half of them making a divergent choice in taking the course for the Health Studies degree.

The analysis of quantitative and qualitative data in the preceding two chapters has revealed details of biographical and professional characteristics of each of the three groups of nurses and it is now pertinent to highlight the salient findings, draw overall conclusions and to outline some areas that would benefit from further research. The biographical and professional data pertinent to research aim one were analysed and discussed in chapter four and will not receive further attention. This chapter will highlight information and findings from the analyses of quantitative and qualitative data that show distinct differences between the populations.

Findings:

Degree Selection Factors

Over one third of community nurses who chose the Health Studies degree, and the same proportion of hospital nurses who chose the Nursing Studies degree, reported they had done so because they considered it to be a natural follow-on (logical progression) from their previous courses. It could be argued that this was what they perceived was expected of them and was what the Institute intended when the courses were designed. In this respect they were aware that they were conforming to expectations.

Having decided that the hospital nurses were the critical group and that those who chose the Health Studies degree were divergent or 'deviant' in switching tracks between the 'logical progression' lines, it was decided to confine the analysis of qualitative data to the hospital nurses on the Health Studies degree with their counterparts on the Nursing Studies degree. The researcher surmised that the reason for their choice of degree must lie in their perception of their professional social realities (Holzner 1968).

In the case of nurses pursuing the Nursing Studies degree, whose course was a logical progression, it suggests that they are getting job satisfaction, have no serious doubts about their future and intend to continue to pursue their chosen career. Health Studies participants, on the other hand, appear to be less interested in nursing per se, are more likely to be experiencing job dissatisfaction and wish to be in a stronger position in case they want to change their career.

The data from the interviews corroborated the quantitative data from the postal questionnaires in showing that most nurses, irrespective of the degree they chose, had given little consideration to undertaking an alternative course. Specific answers that the interviewees gave in response to questions about what led to their decisions to take their particular degree courses, revealed that, 'academic challenge' was three times more likely to be a factor for hospital nurses on the Nursing Studies degree than for those on the Health Studies degree.

Hospital nurses who chose the Health Studies course are strong-minded about their reasons for making their choice and were less likely to be influenced by others. Five Health Studies interviewees mentioned their intention, or a distinct possibility, of a change of career; either from nursing altogether or from 'mainstream' nursing. In contrast, none of the Nursing Studies interviewees raised the possibility of a change of career. Health Studies participants are prepared to take a greater degree of risk than Nursing Studies participants in this respect.

Different Attitudes to Nursing Theory

In the composition of their degree, with regard to the type and number of modules taken: **Nursing Studies students took an average of one and a half more modules in the 'professional studies' group and were also more likely to have taken an extra module above the minimum for graduation.**

Differences between the two groups of hospital nurses were also found in the strength of their belief in the usefulness of nursing theory and nursing models. **Broadly speaking, twice as many Nursing Studies interviewees than their Health Studies counterparts believed it was 'very relevant and valuable' to have knowledge of them. Three times as many Health Studies interviewees said that they were 'of little or no relevance or value'. Six Health Studies nurses said they did not want to study them. In contrast, no Nursing Studies interviewees wished to exclude them; not surprisingly, since they chose this course presumably in the knowledge that two compulsory modules were devoted to nursing theory and models.**

Attitudes to Nursing

There was a difference in the overall attitude to nursing that distinguished the two groups. Those on the Nursing studies course expressed more favourable indicators than their counterparts on the Health Studies, namely, a more positive commitment in making their initial degree choice and a lack of negative views towards the other course, a higher level of satisfaction with their own course at the stage of the interviews, greater interest in taking professional studies modules, including one additional one, and a definite interest in the concepts of nursing, as evidenced by a more positive attitude towards nursing theory and nursing models. **Those who chose the Nursing Studies degree appeared to have a more favourable and committed attitude towards nursing than those on the Health Studies degree.**

Differences Concerning Professionalism and Professional Issues

Generalism versus and Specialism Art versus Science.

The clear differences between the two groups on generalism versus specialism and art versus science lend support to the probability that they are orientated to different models of professionalism. There are also some grounds for supposing that they have internalised different values and attitudes towards the medical profession. The tendency was for Nursing Studies participants to be more strongly in favour of the generalist nurse, rather than the specialist nurse.

Their responses might be interpreted as suggesting that they hold a belief that there is a need for the application of crucial knowledge and skills that essentially form the 'core' of nursing care which can not be acquired and applied through a study of a necessarily narrower range of in-depth study within a specialism. A similar related point that they made was that there was an increasingly tendency to specialise too early in a nursing career before the generalist knowledge and skills had been learnt that, in their view, was undesirable.

Broadly, half of the interviewees said that art and science were of equal importance. Only one from each of the courses said science was more important. **Twice as many on the Nursing Studies course were pro-art, particularly in the field of personal communications (human sensitivities, rapport, counselling and being a good listener). Nursing Studies interviewees were also clearly more supportive of the generalist nurse than the specialist.**

Issues of Professionalisation and Professionalism

Five of the other major issues raised were directly related to professionalisation and professionalism, namely, 'relationships with doctors', 'autonomy', 'professional cohesion' 'professional structure/deskilling/Health Care Assistants', and 'Registered Nurse staffing'. Two other issues were raised, 'conditions of service in the NHS' and 'the public image of nursing'.

Twice as many Nursing Studies as Health Studies respondents were satisfied with their own level of autonomy. Five Health Studies respondents were dissatisfied with the current situation against three Nursing Studies respondents. Both groups displayed a greater degree of optimism than pessimism about gaining autonomy in the future. The difference between the groups did not appear to be related to their personal relationships with doctors in their workplaces, because one half in each of the groups enjoyed good relationships with the doctors with whom they worked.

The greatest amount of pessimism about the future in both groups concerned the professional structure, deskilling and increasing numbers of Health Care Assistants (HCAs) being employed to carry out nursing duties, with too few Registered Nurses in the staffing levels of clinical units. **Health Studies respondents expressed more negative comments and were more pessimistic for the future about this issue. Whilst Nursing Studies respondents cannot be said to be content with the current position, they appear to be 'balanced' in their current and future views.**

Currently, across all seven of the issues raised, among Nursing Studies interviewees there were 15 positive views and 15 negative ones and this did not greatly change in their vision of the future, with 14 optimistic and 17 pessimistic views. Health Studies interviewees, by contrast, expressed less than one third of positive views about the present (23 negative, 7 positive) and an even lower proportion of optimistic views for future (26 pessimistic and only 7 optimistic).

Overall, Nursing Studies participants were more optimistic in attitude in comparison to those on the Health Studies degree. Health Studies participants were generally pessimistic and appeared more frustrated by their positive desire to enhance their position but recognised their powerlessness to do so. There was also a feeling of impotence that came through from a number of comments that were made, including specifically 'lack of cohesion' among their colleagues. Nobody made a direct reference to gender inequalities by

name but some interviewees conveyed this through reference to the relationships of nurses and doctors.

This regularity of responses by both groups was not simply the pronouncement of set views about the same subjects both now and projected into the future. Rather, it was the result of experienced professionals who had thought carefully about the issues that were raised and discussed. Many made comments about the longstanding nature of the problems that they raised, making it clear to the interviewer that they had well-formulated opinions long before the interviews were held. The differences in perception of the 'state of nursing' as it affects them personally in their professional working lives, are likely to have been significant factors that influenced their choice of degree course.

This lends some further support to Nursing Studies participants being more committed to a 'people-centred' model of nursing, more focussed on their immediate role and activities and less concerned with a number of professional issues that do not impact on their own professional lives. **It appears to indicate that nurses who chose the Nursing Studies course are more intrinsically oriented to the human side of nursing, whilst Health Studies participants are more clinically and extrinsically oriented and less tolerant of some of the current difficulties that the profession faces.**

The Findings and the Literature

A number of the findings are now considered which throw light on some major issues for the profession of nursing that were identified in the introduction to this research and in the literature review.

From consideration of the data in table 5.9, although there was a minority who were reasonably content, there was a considerable amount of dissatisfaction expressed about the working conditions of practitioners and the amount of decision-making power that they possessed.

There were distinct differences in orientation and opinions about the current position and status of nursing with regard to the medical profession and the public and a range of perceptions was held about future prospects from quite optimistic to very pessimistic. Acceptance of a subordinate role and a lack of autonomy in deciding patient care is more likely where the ward agenda is dominated by senior doctors (Walby and Greenwell 1994, 11). As Ackroyd found, most of the interviewees expressed a mix of aspects that they were content with as well as a number of dissatisfactions (Ackroyd 1993). Overall, pessimism exceeded optimism about the possibility of an appreciable improvement in the future. Most nurses implied that they were in a weak position in terms of advancing their position as autonomous practitioners. Only relatively small incremental steps had been made by some of them towards this goal and close limits to further progress were acknowledged.

The UKCC's Scope of Professional Practice (UKCC 1992) provides flexibility and opportunities for nurses, both individually and collectively, to extend their practitioner roles and thereby their autonomy but appropriate education must precede attempts to do so. Acquiring the additional education will preclude many but the greater impediment is likely to be a continuing resistance from the medical profession (Walby and Greenwell 1994, Witz 1994).

It is sobering to note that the only example of Nursing Development Units in which nurse practitioner autonomy most clearly existed, were closed due to medical opposition. The medical profession is collegial in terms of its ethos and its modus operandi (Johnson 1972) guarantees practitioner autonomy. Collegiality confers the medical profession's greatest social and political strengths and the functional specialisms into which it has organised – the Royal Colleges - are powerful caucuses. In contrast, nursing is disadvantaged by the mediated nature (Johnson 1972) of its relationships internally, in its professional organisation, and with doctors and health service managers.

It was evident from the interviewees that there was no sense of a collective ideal for further professionalisation and that their focus of thought was very much on their personal circumstances in their places of work and not on a professionalisation strategy. Perhaps the greatest cause for concern was that those who expressed themselves most clearly about the need for professional advancement were those Health Studies participants who were most dissatisfied with their present position, were the most pessimistic and the most likely to leave nursing.

The lack of commitment and even of interest in the utilisation of nursing theory and nursing models by almost half of the nurses interviewed represents a dichotomy in practitioner values and behaviour. Since this is a fundamental difference with tangible effects in practice that will be daily evident, it may hinder the development of a more collegial professional ethos and organisation. This could impair the development of professional cohesion (Brante 1990). Lack of cohesion was a point specifically mentioned by five of the seven Health Studies respondents and a quarter of those on the Nursing Studies degree.

The implications arising from the present level of dissatisfaction with the amount of autonomy, reported by over half of the respondents, is more difficult to interpret since twice as many of these expressed optimism for the future as pessimism. A majority also envisaged that relationships with doctors would improve. The crux of the issue of autonomy seems to be dependent on the extent of progress made on role extension into the present medical domain (MacGuire 1980). Concerns about patient care management and an increase in nurse prescribing rights are two areas where opposition is likely to continue. The second of these will require political support and further legislation.

The professional issue that caused the greatest pessimism to be expressed was the skill mix of the patient care team. The main concern was a dilution of Registered Nurses (RNs) by increasing the number of Health Care Assistants (HCAs). The majority of interviewees saw this as deprofessionalisation (Storch and Stinson

1988, Murphy 1990) and did not want this. The transfer of nursing work and the expansion of nursing knowledge to non-nursing assistants (HCAs) that is occurring, with the intention of politicians and managers of effecting efficiency and economy, is consistent with 'new public management' which is alleged to be anti-professional (Laffin 1998). However, there is a paradox, since it could be argued that fewer RNs would result in them passing work that was less demanding of knowledge and skills to HCAs and increasing the proportion of RN work of a decision-making and supervisory nature, thereby maintaining clear separation in the division of labour. This and the 'rarity' factor would strengthen a claim to professionalism.

The attitudes and the behaviour of the two groups of hospital nurses can be related to the two main models of professionalism. Those who chose the Nursing Studies degree appear to be less concerned with exercising power and, although not content with their current situation, they have adopted a middle ground position and are not overtly confrontational. Nursing Studies participants appear to be more amenable to compromise and to gradual incremental development of their profession. Their opinions and attitudes were consistent with Hugman's (1991) model of the feminine value of nursing in caring *for* clients. It was also clear that they are less likely to leave nursing.

Hospital nurses who chose the Health Studies degree have been shown to think and act more in line with the ***power approach*** to professionalism (Vollmer and Mills 1966, Davies 1996). They were more oriented towards the specialist and technical side of nursing and were more aware of the need to confront those in power positions, doctors and managers, in order to make professional advances. Their opinions and attitudes were more consistent with Hugman's model of the masculine value of caring *about* clients, which he aligns to medicine and the law (Hugman 1991). Health Studies participants also showed explicit signs of pessimism and frustration with their lack of power and most of those interviewed indicated that they would definitely or possibly leave nursing.

Professional boundaries appeared to be important to both groups of hospital nurses. It was obvious from the opinions expressed by members of both of these groups that the dominant professional power of doctors, irrespective of the personal working relationship of individuals, was an issue of some importance. A number of statements made by the interviewees, (two of which were included on page 145), showed resentment about the weakness of the nursing position relative to the doctors (Katz 1966, Freidson 1984). It was easy to visualise doctors engaging in exclusionary and demarcatory strategies and there is no doubt that nurses were engaged in inclusionary activities in their workplaces (Witz 1990, 1994), with or without the concurrence of doctors, (as revealed in comments on pages 147). However, the threat that they saw from the encroachment by HCAs into the nursing domain and in the range of tasks that would take on was seen as a more dominant issue.

In terms of the occupational closure model, (Witz 1990), both groups exhibited a milder *inclusionary strategic* attitude against doctors, compared with their *exclusionary strategic attitude* against Health Care Assistants. This is probably due to the recognition of the relative power of the two professions and because the nurse/doctor boundary is less of a threat to professional nursing, more of a hindrance, and the worst case scenarios merely represent the status quo, whereas progressive infiltration by HCAs is envisaged, accompanied by a reduction in the number of registered nurse posts.

The research has identified that there were distinguishing features within each of the two groups of hospital nurses that appear to have been influential in their decision-making. These features that have been identified and discussed, are different for the two degree courses that were chosen and appear to have become part of the social reality of the majority in each of the respective groups (Berger and Luckmann 1976, Holzner 1968). However, there were some individuals in each group who were unalike in relation to the overall group tendency. This is to be expected by the very fact that the social construction of reality is essentially a personal dynamic.

It is possible that there is a change occurring in the respective numbers of nurses who are oriented towards the alternative professionalisation models. If so, it is more likely that support for the functionalist (altruistic) model would fall, while support for the conflict models would rise. The hospital nurses who chose the Health Studies degree could be among representatives in the vanguard of such a change.

Limits of this Research.

This research was confined to investigating participants on two degree courses in a single institution that specialises in offering courses to nurses and a minority of other health professionals. They lived and worked throughout the whole of South East England and could have chosen to take broadly similar courses in a number of other universities or colleges. No two nurses worked for the same organisation. It is likely that a similar range of opinions and attitudes exists among nurses studying for similar degrees elsewhere but it can not be concluded that the totals of individuals expressing these opinions and attitudes will be quantitatively proportional to those in this study. It is likely that the range of qualitative data will be discerned in a similar study conducted elsewhere, but the small numbers of interviewees involved mean that the findings cannot be said to be numerically representative and it has to be accepted that this study is, in the ways indicated above, unique.

The research showed that course choice was linked to the strength of the participants' allegiance to nursing and to their perceptions of the future development of nursing. The findings are 'time-dependent' and a longitudinal study over a number of years would be necessary to establish the relationship between expressed opinion and attitude now and opinion, attitude and behaviour over time.

It is assumed that the values and attitudes were held before the course decision was made but it is possible that the initially held views were reinforced by their course experiences as well as evolving circumstances at work. The situation in the

particular institution used for this study was unique but the same differences between the two groups of hospital nurses can be expected to exist among similar students and graduates of other institutions that do not offer clear options in the choice of course. Similar research would be required to ascertain this.

This research has uncovered the difference in orientation and attitudes between hospital nurses on the Health Studies and their counterparts on the Nursing Studies degree but it was not designed to determine *why* they were held by these two groups. By the time it was realised that these differences were becoming apparent it was too late and beyond the scope of this essentially limited investigation to attempt to ascertain possible reasons. Research to discover why the two orientations and attitudes formed would need to investigate influences into their initial professional education and aspects of personality.

Research is also desirable in order to elicit the strength of feeling among nurses about the need for the further professionalisation of nursing. This could be designed to determine the existence and extent of inter-professional combative strategies between nurses and doctors, on the one hand, and between nurses and Health Care Assistants on the other. This would indicate the prevalence of behaviour directed at occupational closure.

Further research is desirable to investigate whether the findings of this research are to be found across other higher education institutions. It would also be desirable to ascertain if changes in the strength of support for the professionalisation models are occurring over time.

Implications for Nursing Arising from this Research.

When nurses have a choice in deciding upon a post-registration degree, their *current level of professional* contentment and their perception of future professional development will be *influential in their decision-making. Those* who are relatively content have been shown to have espoused *humanistic, people-*centred values and attitudes that fit the altruistic model of professionalism and to

be intrinsically focused and optimistic towards nursing. They were more likely to have chosen the Nursing Studies degree. Nurses who have greater concerns about the present and future state of nursing professionalism have been shown to have adopted values and attitudes of a more confrontational nature that fits the power approach to professionalism. They are less likely to remain in nursing and are mindful of the desirability of widening their employment options and marketability within and outside of nursing.

The opinions and attitudes that have been discerned about professional nursing issues in this research reflect the circumstances and the issues that exist in hospital and community nurses in workplaces in the health services generally. Some of the opinions expressed indicate a satisfactory state of affairs, with the interviewees experiencing a reasonable level of job satisfaction. The majority, however, harboured serious concerns and evident dissatisfaction.

With regard to continued professionalisation of nursing, the picture is one of contrasts, with areas of comparative brightness, representing localities where doctors and nurses appear to have reached tacit understandings to compromise that enables nurses to advance their professional practice. But elsewhere, the picture appears rather bleak, where nurses are dissatisfied and frustrated to the point of considering deserting their profession, in spite of being relatively privileged in being able to pursue a professionally recognised degree, in most cases with at least some employer support.

The adoption of different 'professionalisation projects' and varying levels of interest and commitment amounts to a tension over strategies for professional advancement for the future and begs a question about the extent to which these dichotomous positions exist among the nursing profession 'out there'. The level of dissatisfaction revealed in this relatively privileged and enlightened sample of nurses and the amount of pessimism expressed about improvements in the future, must be considered to auger badly for the further professionalisation of nursing and for the nursing employment crisis facing the National Health Service. The

fact that there are two clear orientations, if not active agendas, about professionalisation issues and complaints about the lack of cohesion among nurses, will continue to pose a significant problem for organisations that represent nurses, especially for the Royal College of Nursing.

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RCN INSTITUTE STUDENT SURVEY

QUESTIONNAIRE

I have been commissioned to undertake a research project that concerns the characteristics of students at the Institute and I would be very grateful if you would assist me by completing this questionnaire. The research will establish what, if any, patterns have arisen between the personal profiles of the students/graduates, the degrees and modules that they took, how they chose their courses and how useful knowledge and skills acquired on the courses have been in professional practice.

For the purpose of matching profiles to the data on the degrees and modules that is already held on the Institute's computer, it is essential that you identify yourself by your student number. Let me assure you, however, that all of your personal details will be kept strictly confidential and all data used will be aggregated into sub-groups into which your data best fits. Under no circumstances will you be identified, or identifiable, in any report or for any other reason. Depersonalised data will be processed by me on my personal computer at home and possibly at the University of Bristol where I am registered as a doctoral student.

After the data collected in this questionnaire has been analysed, a number of respondents who match particular characteristics relevant to the research will be asked if they will be willing to be interviewed by me to provide additional information and to expand their views of their courses and how they envisage the development of the profession.

JOHN WELLS
Senior Research Fellow

Section 1 Personal particulars

Q1. Please enter your registered Student number. This was issued to you by the Registry. If you are uncertain of it, the Registry will be pleased to confirm it for you.

_____

Q2. Age at the start of your course to the nearest number of years.

_____

Q3. A. Age when you graduated, if applicable. B. Age when you plan to graduate.

(Please circle A or B and write down the age in years.) _____

Please continue on the next page.

Section 2 Educational qualifications

Please enter all your educational qualifications, in descending academic order (eg GCE A level, O level, GCSE). If you had a degree, diploma or certificate BEFORE you started your current degree course, please enter at the top of your list.

Level	Subject	Grade	Year

Section 3 Professional qualifications and experience

Q4. Which parts of the UKCC Register are you on?
(Please enter all parts and give dates when first qualified for them)

Parts of Register	Dates

(Please round to the nearest number of whole years)

Q6. What was your job title at the time you started your degree course? _____

Please continue on the next page.

Q7. What was your job (pay) grade when you started your degree course? _____

Q8. Since starting your degree course have you been appointed to a higher or better post? ☐ Yes
(Either through promotion to a higher grade or to a more desirable but not higher post.) ☐ No

Q9. What is your present job (pay) grade? _____

Q10. What is your present job title? _____

Section 4 Your degree

Q12. Why did you choose to take a degree course at the Institute? (If you give more than one reason please rank them, giving the most important rank 1 and so on.)

Q13. Why did you choose the particular course that you are taking, or have completed? (Give up to three reasons, ranking them with the most important as number one.)

Q14. Did you give serious consideration to taking other degree courses within the Institute?

☐ Yes (now go to Q15)

☐ No (now go to Q16)

Q15. If Yes, write in those that you did consider taking and state your reason/s for NOT doing so.

Please continue on the next page

Q16. Which of the following statements comes closest to your perception of the value that the degree will be to your current and intended professional role/s?

- ☐ a. vital and indispensable
- ☐ b. high value and relevance
- ☐ c. moderate value and relevance
- ☐ d, low value and relevance

Q17. Which taught module did you find to be the most difficult? (Please write the Title of ONE module below)

_____

Q18. Which of the following statements comes closest to your perception of this most difficult module?

- ☐ a. extremely complex and difficult
- ☐ b. moderately complex and difficult
- ☐ c. not very complex and not too difficult
- ☐ d. straightforward and not difficult

If you have not completed your dissertation please enter N/A for Q19 and ignore Qs 20 to 22.

Q19. What is your estimate of the total number of hours you spent on your dissertation?

(Answer only if you have completed and submitted it. Calculate this figure as accurately as you can and enter a whole number) _____

Q20. Which of the following statements best fits your perception of how difficult you found your dissertation to be?

- ☐ a. extremely demanding
- ☐ b. moderately demanding
- ☐ c. not very demanding
- ☐ d. undemanding

Q21. What is/was the subject of your dissertation?

_____

Q22. How relevant is your dissertation to your current professional practice?

- ☐ a. Very relevant
- ☐ b. Moderately relevant
- ☐ c. Slightly relevant
- ☐ d. Not at all relevant

If required, I agree to being contacted by the Researcher for an interview. YES / NO

Thank you for completing this questionnaire. Please post it in the prepaid envelope supplied.

Postal Questionnaire: Format, Section Titles and Categorisation Plan

The Section titles and a brief outline content of each of them are as follows: **Section 1 Personal Particulars;** asked correspondents to identify themselves by their PIN, to give their age at the start of their degree course and their age at graduation or when they planned to graduate. (Names were not used at any stage during the quantitative stage and only those subjects who were selected for the qualitative stage, with their agreement, had their names, addresses and telephone numbers supplied by the Registry of the Institution, in accordance with the requirements of the Data Protection Act as licensed). **Section 2 Educational Qualifications;** asked them to enter all of their educational qualifications at secondary and post-secondary level. **Section 3 Professional Qualifications and Experience;** was concerned with the parts of the UKCC Register that they were on, the year they were first registered, their job title and pay grade at the start of their degree course, whether they had progressed in their careers since starting their degree course and their present job title and pay grade. **Section 4 Your Degree;** asked them for the reason/s for choosing their particular course and whether and what alternative course they also considered taking. Further questions asked for their evaluation of the utility of their course to their current practice. They were asked to identify the most difficult module that they had taken and the extent of any difficulty. Four further questions were asked about their dissertation, if they had yet undertaken it.

Categorisation Plan.

It was necessary before the formulation of the postal questionnaire to have made some fundamental decisions about how the data would be analysed and the subjects assigned to categories that would be useful for selection of the sample for the qualitative stage. The researcher drew up the following categorisation plan that could either be used without modification or with some modification in the light of provisional findings from the data extracted from the questionnaires.

Age at the start of the course

The researcher was aware that the ages of students on the courses ranged from the early twenties to the late forties. He considered it necessary to separate the respondents into age bands but he made no decision at this stage about the number and extent of the age bands that would be used in the analysis. Because of the fact that community-based nurses have to have had experience of hospital work before they are eligible to go on to gain community nursing qualifications and then obtain a suitable post that they would be found to be older, on average, than the hospital-based nurses.

Age at graduation or planned graduation

as above.

Educational attainment and entry gate to the degree programme

1. Those with 2 or more GCE A level subject passes or higher (normal university entrance).
2. Those with a post-registration qualification at higher education level.
3. Those outside categories 1 and 2 who were admitted through passing an entrance test approved for registration by the University of Manchester, (the validating authority).

It was suspected that there would be a larger proportion of community nurses than hospital nurses with a post-registration qualification at the higher education level.

Professional qualifications

1. Those who have only a **general** nursing qualification.
2. Those who have a general nursing qualification plus one or more other qualifications enabling entry to additional parts of the register.
3. Those who do not have a general nursing qualification but who are on other parts of the register.

The researcher had a hunch that there would be comparatively few nurses without a general nursing qualification and, those who were not general nurses, would be more likely to have chosen the Health Studies degree. He had no preconceptions about those who were on two or more parts of the Register.

Decade of qualification

It was thought appropriate to separate respondents into the decade of their first registration with the relevant national registration body, 1960s, 1970s, 1980s, and 1990s.

Number of years of professional work

This category was decided upon to ascertain whether any differences occurred in the total number of years worked, excluding time out for any reason, between nurses in different work sectors (hospital and community) and those on different courses. No decision had been made at this stage about category boundaries.

Place of work and job titles at start of course

1. The main distinction would be made between hospital and community based nurses.
2. Job titles to distinguish the spread of professional roles and seniority.

Seniority of professional post at time of degree registration

Neither job grades or job titles are sufficient to place a substantial number of respondents relative to one another in terms of seniority because job titles and job grades are used too loosely and flexibly to make direct comparisons meaningful. It was considered necessary to obtain both. The job grade is the more significant of the two in most cases since this determines pay and is more likely to be regarded as promotion than a change in job title. The following bands were decided:

1. grades D or E or equivalent.
2. Grades F or G or equivalent.
3. Grade H or higher or equivalent.

Percentage of staff promoted and present grades

It was decided to ask respondents to give their present grade as well as the grade they were on at the start of the course. This would indicate promotion in terms of pay. However, notwithstanding the comment made under the previous heading, some nurses consider that they have gained career advancement through appointment to a better 'career' post. Question 8 specifically asked about this. Promotion would be regard as assimilation to a higher grade or on the subjects subjective opinion of career advancement regardless of current grade.

Degree selection factors

Three questions were included to elicit preferences and attitudes to the different degree courses. No preconceived ideas for categorisation were held prior to data analysis.

Degree course valuation of utility

Respondents were asked to give their perception of the value of their degree to them in terms of it's utility in their professional role. Four possible responses were provided.

Level of academic difficulty

It was decided to ask respondents to indicate how difficult they found the hardest module and the dissertation to be. This was in order to elicit whether their were differences between the two courses. Again a range of four possible responses were available for the answers to each of the questions. The researcher thought it possible that graduates of the Nursing Studies degree might find their dissertation generally more demanding than Health studies graduates. He had heard comments expressed by a number of them who believed this to be the case.

Utility of the dissertation

The remaining question asked respondents to say how relevant they found their dissertation to be in relation to their current professional practice. Again four possible answers were available for selection, ranging from very relevant to not relevant at all.

INTERVIEW SCHEDULE / ANALYSIS AND CODING FRAME

Q1. How did you come to be in nursing?

a)	b)	c)
Only occupation	changed from **trained** occupation	changed from **untrained** occupation

Q2 Would you briefly sketch out your career, with places, courses, roles and dates.

a)	b)	c)	d)
restricted in range/scope	reasonable range/scope	wide and varied but not very developmental	wide and varied with impressive career development

Q3. How would describe your present job/title?

a)	b)	c)	d)	e)	f)
hospital direct care	hospital management	community direct care	community management	professional education	clinical development/education

Q4 How long have you been in your present job/role?

a)	b)	c)	d)	e)
up to 1 year	1 to 2 years	2 to 3 years	3 to 5 years	over 5 years

Q5. In relation to your degree course, when were you appointed to your present job/role?

a)	b)	c)
before starting course	during the course	after graduating

Q6. Would you describe what sort of things you considered that lead to your decision to take your degree corse.

a)	b)	c)	d)
academic challenge	demands of role/ to develop higher level of practice	work colleagues influence	career advancement/ambition/professional prestige

Q7. Why did you choose the (Health or Nursing) Studies degree rather than another option?

a) gave little consideration before deciding

b) decision based on future career change

c) decision based on "best fit" to present job/role

d) decision involved conceptual / considerations

e) advised to take by colleague manager

f) wanted more focal/broader degree

g) did **not** want Health/Nursing degree

Q8. Can you describe your concept of nursing? / What are the essentials for effective nursing?./ What does it take to be a good nurse?

a) clear, comprehensive and well conceived

b) made an effort but was vague and lacking in breadth/depth

c) made little effort and was far from saisfactory or declined

Q9. Can you describe your concept of health? / What does it take to be positive about health and a healthy lifestyle? / What are your thoughts about health and health promotion?.

a) clear, comprehensive and well conceived

b) made an effort but was vague and lacking in breadth/depth

c) made little effort and was far from saisfactory

C2

Q10. What are your impressions about the modular degree course structure and the range of modules available?

a) very satisfied/good range of modules/ good fit to job/role

b) moderately satisfied/would have like greater choice of modules/quite relevant to job/role

c) dissatisfied overall/inadequate choice of modules/not very relevant to job/role

Q11. These are the modules that you took. How did you go about choosing which modules to take? What were the deciding factors?

a) relevance of role

b) personal academic interest

c) previous study of subject

d) perception of ease/difficulty of subject

e) time when module/s run

Q12. Which of the modules that you took has been the most valuable to your work?

Q13. Are there any other modules that are useful to your work?

Q14. How relevant or valuable do you think it is to have a knowledge of nursing theory and nursing models?

a)	b)	c)
very relevant/valuable	moderately relevant/valuable	of little or no relevance/value

Q15. To what extent did your course provide you with knowledge of nursing theory and nursing models?

a)	b)	c)	d)	e)
More than required/desired	About the right amount	Less than required/desired	did not want to study them	not sure yet

Q16. To what extent do you apply nursing theory or/and nursing models in your practice?

a)	b)	c)
usually/frequently	occasionally/when necessary	rarely/never

Q17 There has been a debate about `generalism' vesus `specialism' in nursing over the past few years which appears to have intensified over the introduction of Nurse Specialists. Some argue that the profession still needs generalists, while others advocate the development of more specialists. Where do you stand on the apparent dichotomy?

a)	b)	c)	d)
Pro-Generalism	Pro-Specialism	neutral / both	undecided / uncommitted

Q18 Nursing can be said to be based upon **art** on the one hand and **science** on the other but there are differences to be found among nurses and others on the relative importance of each of these underpinning components. What is your opininon of the relative importance of the `art' side and the `science' side of nursing?

a)	b)	c)	d)
Pro-Art	Pro-Science	of equal importance	undecided / uncommitted

Dissertation

Q19 How valuable was your dissertation from the personal academic perspective?

a)	b)	c)	d)	e)
very valuable	moderately valuable	of little or no value	has not completed	has not started

Q20. How valuable was the dissertation from the professional knowledge and/or skills perpective?

a)	b)	c)	d)	e)
very valuable	moderately valuable	of little or no value	has not completed	has not started

Q21. How academically demanding was your dissertation?

a)	b)	c)	d)	e)
very demanding	moderately demanding	not (very) demanding	has not completed	has not started

Q22. What advice would you give to someone who may be following a similar career path to you about taking/choosing a degree programme?

a)	b)	c)	d)	e)
take very similar course/s	match academic content/skills the course offers to job/role	take a different (named) degree course	do **not** take a named degree course	other option

Q23. How do you see the nursing profession developing over the next few years?/ What major issues have to be confronted/overcome?

a)	b)	c)	d)	e)	f)	g)
relationships with doctors	autonomy	public image	prof. structure de-skilling/HCAs	standards of care	recruitment/ retention	conditions of service

NOW
Positive

Negative

FUTURE
Positive

Negative

Fully Detailed Tables of Quantitative Data

The tables contained in this Appendix display the more detailed analysed results of the quantitative data that were discussed in chapter 4. The table numbers correspond to the table numbers in chapter 4. Refer to chapter 4 for an explanation of data management.

START DATES AND PROGRESS RATES TO GRADUATION

		Health Studies		Nursing Studies	
	Start Year	Persons	%	Persons	%
Graduated 1995					
	<1990	2	2%	8	11%
	1991	16	13%	18	25%
	1992	16	13%	16	22%
	1993	53	44%	25	35%
	1994	37	30%	3	4%
		124	100%	72	100%
Graduated 1996					
	<1991	11	6%	10	17%
	1992	11	6%	12	18%
	1993	48	27%	27	40%
	1994	50	28%	16	24%
	1995	60	33%	3	4%
		180	100%	68	100%
Students 1996/97					
	<1992	8	4%	7	5%
	1993	15	8%	14	10%
	1994	40	22%	27	20%
	1995	61	34%	32	24%
	1996	57	31%	56	41%
		181	100%	136	100%

Table 4.1e

From Table 4.1e, with reference to graduation and start dates, it can be seen that, in the graduate cohorts, there were students who graduated one and two years after registration for their degree. The larger numbers of graduates in Health Studies in 1995 and 1996 were largely due to a 'backlog' of students holding an Occupational Health Nursing diploma or certificate, some of whom completed their OHN courses many years previously. They were encouraged to top-up to a degree by their professional associations. These occupational health nurses were a mix of externally and internally qualified ones. The graduates of these two years also included a number of progression students from the Nurse Practitioner diploma course. It should be stated that student drop out rates for all Institute courses are low and typically in the region of 8% to 10%.

It can be seen from the student numbers in the academic year 1996/97 that the bulge has passed and the student progression figures, in percentage terms, for the two degrees are quite close at 16% and 18%. When the first three start years and the last two are grouped, the percentages are

the same. The percentages of progression students were also very similar. The figures for progression students in all three of the Nursing Studies cohorts show far less fluctuation. No reason could be found for the dip to 10% in the 1996 progression graduates.

PLACE OF WORK AND JOB TITLE AT START OF COURSE

	<---------- Hospital-based ---------->				<---------- Community-based ----------					
	Staff Nurse	Ward Sister	Clinic Spec'st		Distr Nurse	Hlth Vis'r	O H Nurse	Pract Nurse	Nurse Prac'r	Other
Health Studies										
1995 n= 9	6 16%	2 5%	1 3%	**n=22**	6 16%	0	6 16%	6 16%	2 5%	2 5%
1996 n=34	25 33%	7 9%	2 3%	**n=40**	3 4%	1 2%	12 16%	20 26%	3 4%	2 3%
1996/97 n=47	29 39%	9 12%	9 12%	**n=21**	1 2%	2 3%	7 9%	5 7%	0	2 3%
Totals 90	**60 68%**	**18 20%**	**11 12%**	**83**	**10 12%**	**3 4%**	**25 30%**	**31 37%**	**5 6%**	**6 7%**
Nurs'g Studies										
1995 n=26	12 40%	8 27%	2 7%	**n= 4**	0	0	0	0	0	4 15%
1996 n=21	15 49%	5 18%	1 4%	**n= 0**	0	0	0	0	0	0
1996/97 n=53	39 75%	9 15%	4 7%	**n= 1**	0	0	0	0	0	1 2%
Totals 100	**66 66%**	**22 22%**	**7 7%**		**0**	**0**	**0**	**0**	**0**	**5 5%**
				5						

Table 4.2e/4.3e

AGE IN YEARS AT COMMENCEMENT OF COURSE

		Under 25		26 - 30		31 - 35		36 - 40		41 & Over	
Health Studies		**a**	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**
1995 - Comm-based	**n=22**	0		5	23%	4	18%	3	14%	10	45%
1996 „	**n=40**	1	2%	9	23%	6	15%	13	32%	11	27%
1996/97 „	**n=21**	0		3	14%	5	24%	5	24%	8	38%
Total	**83**	**1**	**1%**	**17**	**20%**	**15**	**18%**	**21**	**25%**	**29**	**35%**
1995 - Hosp-based	**n= 9**	1	11%	5	56%	2	22%	0		1	11%
1996 „	**n=34**	9	26%	13	38%	8	24%	2	6%	2	6%
1996/97 „	**n=47**	10	21%	22	47%	5	11%	6	13%	4	8%
Total	**90**	**20**	**22%**	**38**	**42%**	**15**	**17%**	**8**	**9%**	**7**	**8%**
Nursing Studies											
1995- Hosp-based	**n=26**	4	15%	14	54%	4	15%	2	7%	2	7%
1996 „	**n=21**	8	38%	5	28%	4	19%	4	19%	0	
1996/97 „	**n=53**	14	26%	18	34%	9	26%	6	11%	6	11%
Total	**100**	**26**	**26%**	**37**	**37%**	**17**	**17%**	**12**	**12%**	**8**	**8%**

Table 4.5e

EDUCATIONAL ENTRANCE QUALIFICATIONS

		Cat 1 - A levels		Cat 2 - Prof Quals		Cat 3 - Entr'ce Test	
Health Studies		**a**	**b**	**c**	**d**	**e**	**f**
1995 - Com-based	**n=22**	9	41%	6	27%	7	32%
1996 „	**n=40**	14	35%	15	38%	11	27%
1996/97 „	**n=21**	14	67%	2	9%	5	24%
Total	**83**	**37**	**44%**	**23**	**28%**	**23**	**28%**
1995 - Hosp-based	**n= 9**	4	44%	0		5	56%
1996 „	**n=34**	21	62%	1	3%	12	35%
1996/97 „	**n=47**	23	49%	1	2%	23	49%
Total	**90**	**48**	**54%**	**2**	**2%**	**40**	**44%**
Nursing Studies							
1995 - Hosp-based	**n=26**	17	65%	0		9	35%
1996 „	**n=21**	15	71%	0		6	29%
1996/97 „	**n=53**	38	72%	0		15	29%
Total	**100**	**70**	**70%**	**0**		**30**	**30%**
1995 - Com-based	**n= 1**	0		0		1	100%
1996 „	**n= 0**	0		0		0	
1996/97 „	**n= 1**	1	100%	0		0	
Total	**2**	**1**	**100%**			**1**	**100%**

Table 4.6e

PROFESSIONAL QUALIFICATIONS

		General Register only		General plus other part of Register		Gen + Comm Specialist Qualification		Other part of Register only	
Health Studies		**a**		**b**		**c**		**d**	
1995 - Comm-based	**n=22**	9	41%	2	9%	10	45%	1	5%
1996 „	**n=40**	13	33%	7	17%	20	50%	0	
1996/97 „	**n=21**	8	38%	5	24%	8	38%	0	
Total	**83**	**30**	**36%**	**14**	**17%**	**38**	**46%**	**1**	**1%**
1995 - Hosp-based	**n= 9**	8	89%	1	11%	0		0	
1996 „	**n=34**	24	71%	8	24%	1	3%	1	3%
1996/97 „	**n=47**	36	76%	5	11%	2	4%	4	8%
Total	**90**	**68**	**76%**	**14**	**16%**	**3**	**3%**	**5**	**6%**
Nursing Studies									
1995- Hosp-based	**n=26**	19	73%	4	15%	1	4%	2	8%
1996 „	**n=21**	16	76%	3	14%	0		2	10%
1996/97 „	**n=53**	40	75%	6	11%	1	2%	6	11%
Total	**100**	**75**	**75%**	**13**	**13%**	**2**	**2%**	**10**	**10%**

Table 4.7e

DECADE OF QUALIFICATION

Health Studies			1960s		1970s		1980s		1990s	
			a	b	c	d	e	f	g	h
1995 - Comm-based		n=22	5	23%	7	32%	10	45%	0	
1996	„	n=40	4	10%	17	43%	19	47%	0	
1996/97	„	n=21	1	5%	11	52%	8	38%	1	5%
Total		**83**	**10**	**12%**	**35**	**42%**	**37**	**46%**	**1**	**1%**
1995 - Hosp-based		n= 9	0		0		7	78%	2	22%
1996	„	n=34	0		5	15%	13	39%	16	47%
1996/97	„	n=47	2	4%	4	8%	21	45%	20	43%
Total		**90**	**2**	**2%**	**9**	**10%**	**41**	**46%**	**38**	**42%**
Nursing Studies										
1995- Hosp-based		n=26	0		5	17%	23	77%	2	7%
1996	„	n=21	0		3	14%	6	29%	12	57%
1996/97	„	n=53	2	4%	7	13%	25	47%	19	36%
Total		**100**	**2**	**2%**	**15**	**15%**	**54**	**54%**	**33**	**33%**

Table 4.8e

NUMBER OF YEARS OF PROFESSIONAL WORK

Health Studies			21 & Over		16 - 20		11 - 15		6 - 10		Under 5	
			a	b	c	d	e	f	g	h	I	j
1995 - Comm-based		n=22	6	28%	5	23%	6	28%	4	18%	1	5%
1996	„	n=40	9	22%	13	22%	11	27%	7	18%	0	
1996/97	„	n=21	4	19%	7	33%	5	24%	4	19%	14	5%
Total		**83**	**19**	**23%**	**25**	**30%**	**15**	**18%**	**15**	**18%**	**2**	**2%**
1995 - Hosp-based		n= 9	2	22%	0		2	22%	4	44%	1	11%
1996	„	n=34	0		4	12%	5	15%	12	35%	13	38%
1996/97	„	n=47	2	4%	2	4%	6	13%	19	40%	18	38%
Total		**90**	**4**	**4%**	**6**	**7%**	**13**	**14%**	**35**	**39%**	**32**	**36%**
Nursing Studies												
1995- Hosp-based		n=26	1	4%	2	8%	10	38%	11	42%	2	8%
1996	„	n=21	1	5%	3	14%	6	29%	5	24%	2	29%
1996/97	„	n=53	3	6%	10	19%	11	21%	17	32%	12	27%
Total		**100**	**5**	**5%**	**15**	**15%**	**27**	**27%**	**33**	**33%**	**20**	**20%**

Table 4.9e

DEGREE SELECTION FACTORS

		Considered other Deg? Yes a	No b	+Own Degr c	Other Degr d	Both (c) and (d) e	Neut/No Comment f	Logical Progress g
Health Studies								
1995 Com-based	**n=22**	6 28%	16 72%	8 37%	0	1 5%	5 23%	8 37%
1996	**„ n=40**	8 22%	32 80%	16 40%	1 5%	3 7%	8 20%	13 32%
1996/97	**„ n=21**	3 14%	18 86%	6 29%	1 5%	3 14%	4 16%	7 19%
	Total 83	**17 20%**	**66 80%**	**30 36%**	**2 2%**	**7 8%**	**17 20%**	**28 34%**
1995 Hosp-based	**n=9**	2 22%	7 78%	6 67%	0	1 11%	2 22%	0
1996	**„ n=34**	11 32%	23 68%	19 56%	1 3%	9 26%	5 15%	0
1996/97	**„ n=47**	12 26%	35 74%	27 57%	2 4%	15 32%	3 6%	0
	Total 90	**25 28%**	**65 72%**	**52 58%**	**3 3%**	**25 28%**	**10 11%**	**0**
Nursing Studies								
1995 Hosp-based	**.n=26**	10 38%	16 62%	10 34%	0	1 3%	7 23%	7 23%
1996	**„ n=21**	6 29%	15 71%	8 30%	0	0	12 44%	7 26%
1996/97	**„ n=53**	14 26%	39 74%	13 22%	0	4 7%	21 36%	21 36%
	Total 100	**30 30%**	**70 70%**	**31 31%**	**0**	**5 5%**	**40 40%**	**35 35%**

Table 4.10e